California Mental Health Services Authority
Statewide Prevention and Early Intervention Implementation Work Plan

November 12, 2010
**Executive Summary**

The Statewide Prevention and Early Intervention (PEI) Implementation Work Plan presents how the California Mental Health Services Authority (CalMHSA) will implement $129 million in Mental Health Service Act funds to prevent suicides, reduce stigma and discrimination, and improve student mental health. The work plan outlines the recommended actions selected from the MHSOAC’s three Strategic Plans.

The PEI Implementation Work Plan is built on a foundation of an extensive statewide stakeholder input process conducted over three years for suicide prevention and stigma and discrimination reduction resulting in CalMHSA prioritizing and constructing the plan contained herein. A different stakeholder process was used for student mental health. Recommendations from the stakeholders were continuously considered, reviewed and included in the plan presented. Continued stakeholder participation is essential to the successful implementation of the statewide plan.

**Background**

In 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which directs counties to develop, through an extensive stakeholder process, a broad approach to providing statewide PEI services and education for California mental health consumers. In January and September of 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five PEI Statewide Projects and corresponding funding amounts. In 2008, the MHSOAC approved three PEI Statewide Projects for implementation: Suicide Prevention (SP), Stigma and Discrimination Reduction (SDR), and the Student Mental Health Initiative (SMHI). Strategic Plans were written for each project:

- **California Strategic Plan on Suicide Prevention: Every Californian Is Part of the Solution** (approved June 30, 2008)
- **California Strategic Plan on Reducing Mental Health Stigma and Discrimination** (approved June 25, 2009)
- **Student Mental Health Initiative** (approved May 2010)

CalMHSA, a Joint Powers Authority (JPA), was formed July 2009 as solution to providing fiscal and administrative support in the delivery of mental health services. As of this writing there are 29 of California’s 58 counties as members. In April 2010, the Department of Mental Health (DMH) contracted with CalMHSA to administer the funding and implementation of mental health services, projects and educational programs at the state, regional and local levels.
Executive Summary

Approximately 85% of the MHSA funds ($160 million) allocated for statewide PEI have been committed for the CalMHSA implementation. As membership continues to evolve, revision of the plan will be provided.

In June 2010, CalMHSA formed an Implementation Ad Hoc Committee, made up of five board members and promptly included stakeholder participation. Starting on July 7, 2010, the Ad Hoc Committee conducted a 52-day stakeholder input period. The Implementation Ad Hoc Committee worked closely with stakeholders to select recommended actions from the three Strategic Plans. The selected recommended actions were presented to and approved by the CalMHSA Board of Directors at their September 10, 2010 meeting. The Committee meetings continued and resulted in the Board approving two additional recommended actions to be included in the work plan. Over the following month, CalMHSA created, with continuous participation from stakeholders, a draft Implementation Work Plan, which was posted for a 30-day public comment on October 7, 2010. At the November 12, 2010 CalMHSA board meeting, the finalized Implementation Work Plan will be reviewed for approval and submission to the MHSOAC.

Following MHSOAC approval, Requests for Proposal (RFPs) will be released over the first quarter of 2011, containing detailed scopes of work and budget information for each designated program. Three expert review panels comprised of subject matter experts will rank the bidders best equipped to carry out the collective vision of the MHSA, DMH, MHSOAC, the stakeholders and CalMHSA. During program implementation, a rigorous program specific and statewide evaluation will be initiated to ensure programs fulfill the MHSA’s goals and objectives. Each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. Program specific and statewide evaluation will advance understanding of effective methods to provide desired outcomes.

Purpose

CalMHSA’s Implementation Work Plan is intended to provide a framework and narrative for implementing MHSA funds in the most efficient and effective manner. Central to CalMHSA’s vision is the promotion of systems and services arising from community mental health initiatives while respecting the California MHSA values:

1. community collaboration and cultural competence,
2. client-driven mental health system for children, transition age youth, adults and older adults,
3. family-driven system of care for children and youth,
4. wellness focus, including recovery and resilience, and
5. integrated mental health system service experiences and interactions.
Feedback and guidance were obtained from stakeholders representing various life stages and populations in order to guarantee the most comprehensive, values-driven plan possible. Moving forward the Implementation Work Plan will serve as a guide throughout implementation.

Report Structure
The Implementation Work Plan provides an overview and background of the Statewide PEI Projects and the Strategic Plans being realized through CalMHSA, along with a detailed look at the recommended actions selected for the initial phase of implementation. The strategic plans are presented in three sections. Each section contains priorities, themes, recommended actions and budget information; a budget summary and program overview of all three initiatives is detailed in Appendix 1.

- **Section A. CalMHSA Implementation Work Plan on Suicide Prevention**
  1. Create a System of Suicide Prevention
  2. Educate Communities to Take Action to Prevent Suicide
  3. Implement Training and Workforce Enhancements to Prevent Suicide
  4. Improve Suicide Prevention Program Effectiveness and System Accountability

- **Section B. CalMHSA Implementation Work Plan on Stigma and Discrimination Reduction**
  1. Creating a Supportive Environment for All Consumers and Those at Risk for Mental Health Challenges
  3. Increasing Knowledge of Effective and Promising Programs and Practices

- **Section C. CalMHSA Implementation Work Plan on Student Mental Health Initiative**
  1. Design and administer programs that will focus on three key strategic directions: training, peer support activities and suicide prevention.
  2. Design and administer programs that address the systemic challenges in providing a comprehensive approach to addressing student mental health.

Financial Summary
Currently the Implementation Work Plan provides for the implementation of $129 million in MHSA funds over the next four years. This detail is provided in Appendix 1. The funding request is based on the amount of available funding, Phase II (non-planning) funds, projected membership and the allocation targets for the three projects (25% Suicide, 37.5% Stigma and 37.5% SMH).
Implementation

CalMHSA’s first step in implementing the Implementation Work Plan will be to issue Request for Proposals (RFPs)/Request for Qualifications (RFQs)/Request for Applications (RFAs) during the first quarter of 2011. Preliminary to writing RFPs/RFQs/RFAs, CalMHSA will conduct focus groups on: Suicide Prevention, Stigma and Discrimination Reduction, Higher Education (Student Mental Health) and K–12 (Student Mental Health). Consumers, family members and other stakeholders will be invited to participate. These meetings will provide participants opportunities to participate in the preparation and assistance in the development of the scopes of work for the RFPs/RFQs/RFAs. Staff will then write RFPs/RFQs/RFAs with assistance from subject matter experts, including consumers and family members with lived experience, cultural diversity knowledge, and others with different professional expertise such as research and evaluation. Review panels will be formed using the same range of subject matter experts to assist with rating the proposals submitted for implementation.

Upon approval of the Implementation Work Plan by the MHSOAC and DMH, implementation will occur in three stages, first Suicide Prevention, second Stigma and Discrimination Reduction and third Student Mental Health. Each stage will last approximately three months, with two week intervals between start of each phase. Each stage will have a specific date (TBD) for release of program RFPs/RFQs/RFAs, a specified period for submission, a review panel convened that recommends selection for full CalMHSA board approval, contract negotiations initiated and contract finalized, and implementation begins.

Implementation will feature statewide media campaigns to prevent suicides and reduce stigma and discrimination. The Implementation Work Plan will solicit focused strategies to educate the public, health care providers, educators, families and individuals about understanding suicide risk factors, the many barriers to help seeking and acceptance of support of persons with mental illness. Statewide initiatives will include local and regional strategies, tailored to California’s cultural, geographic diversity, and include programs that will have impact across the age spectrum.

The prevention efforts contained herein are capable of results similar to public health efforts that reduced tobacco use and prevented the spread of HIV infection. The Statewide PEI Implementation Work Plan to prevent suicides, reduce stigma and discrimination, and improve student mental health will have a significant impact on the mental health of California residents now and for generations to come.

Respectfully Submitted:

Board of Directors
California Mental Health Services Authority (CalMHSA)
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This Implementation Work Plan describes how $129 million of Mental Health Service Act funds will be utilized to implement California’s Statewide Prevention and Early Intervention (PEI) Plan to Prevent Suicides, Reduce Stigma and Improve Student Mental Health.

The California Mental Health Services Authority (CalMHSA)

The California Mental Health Services Authority (CalMHSA) is an independent administrative and fiscal government agency focused on the efficient delivery of California mental health projects. California counties established CalMHSA as a Joint Powers Authority (JPA). Member counties worked together to develop, fund and implement mental health services, projects and educational programs at the state, regional and local levels.

California is the third largest state in the United States, encompassing 163,696 square miles. There are 58 counties and two city programs in California, with Los Angeles as the largest population and San Bernardino as the largest county by area. Of those 58 counties, 29 are member counties of the CalMHSA at time of submission of this plan; and the detail is provided on page A1.8 of the Appendices.

CalMHSA is headed by a separate Board of Member Counties and an Executive Committee comprised of officers and Statewide Regional Representatives. It employs the administrative firm of George Hills Company, Inc. and separate legal counsel of Murphy, Campbell, Guthrie & Alliston. CalMHSA operates within the statutes governing Joint Powers Agreement (JPA) entities and complies with the Brown Act open meeting requirements.

CalMHSA has the capacity and capability to promote systems and services arising from a shared member commitment to community mental health. A central part of CalMHSA’s vision is to promote systems and services arising from community mental health initiatives and to respect the values of the California Mental Health Services Act. These are: 1) Community Collaboration; 2) Cultural Competence; 3) Client driven mental health system for individuals of any age who are receiving or have received mental health services; 4) Family driven mental health system for families of children and youth diagnosed with serious emotional disturbance; 5) Wellness, Recovery, and Resilience Focused; and 6) Integrated Service Experiences for clients and their families.

Overview of Prevention and Early Intervention Statewide Programs

In January and September of 2007, the Mental Health Services Oversight and Accountability Commission (MHSOAC) approved five PEI Statewide Projects and corresponding funding amounts. In May 2008, the MHSOAC determined that three of the PEI Statewide Projects would be most effectively implemented through a single administrative entity. The MHSOAC approved
a combined funding level of $40 million each year for four years specifically for these three projects: Suicide Prevention-SP ($10 million per year, 25%), Stigma and Discrimination Reduction-SDR ($15 million per year, 37.5%) and Student Mental Health Initiative-SMHI ($15 million per year, 37.5%). Initially the California Department of Mental Health (DMH) agreed to administer and implement these projects contingent upon 1) the counties completing agreements to assign funds to DMH for these purposes and 2) receiving expenditure authority in the state budget. The idea at that time was to have the PEI Statewide Programs developed in collaboration with the California Mental Health Directors Association (CMHDA), the MHSOAC and Stakeholders. Counties would benefit directly and indirectly from these statewide projects through training and technical assistance provided to counties and their PEI partners, support for the implementation of local PEI Projects, media and social marketing materials in multiple languages, model program sites, enhanced state and local partnerships, coordinated state and local efforts, research and evaluation and statewide quality improvement activities. This process proved to be relatively inefficient and resulted in unanticipated delays. During 2009 the Counties, MHSOAC and the DMH determined that a more efficient and effective method of implementing the Statewide PEI initiatives was to use a JPA such as CalMHSA.

CalMHSA was formed in July 2009, by the initial six formation counties. During the next nine months the JPA worked on developing strategic plans, growth of membership, policies and procedures, staffing and other resources, and executing a contract with DMH for the Statewide PEI funds of $160 million.

Upon execution of the contract, CalMHSA increased resources and launched into action, principally performing the elements of the MHSOAC Guidelines and starting with gathering stakeholder input and establishment of the CalMHSA Implementation Ad Hoc Committee. CalMHSA stakeholders requested additional accommodations for more focused input. CalMHSA’s Ad Hoc Committee readjusted some of the timelines in response to this request. Stakeholders have been provided an active role throughout the process of the development of the CalMHSA Implementation Work Plan.

CalMHSA staff held regularly scheduled meetings with the CDMH Office of Suicide Prevention (OSP) leadership and conferred by telephone throughout the process in the development of the work plan. Collaboration was guided by the work plan that OSP had developed and was ready to implement. OSP provided a matrix display of its current and planned work as a resource for CalMHSA to identify PEI Implementation Work Plan activities that are congruent with, collaborative and complementary to the efforts of OSP.

The CalMHSA Implementation Work Plan that follows is the framework for the implementation of Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health. Since
not all Counties have joined CalMHSA, the Plan will implement eighty-five percent of the available resources.

**Statewide Framework for Implementation of PEI Plans**

The MHSOAC PEI Principles and Policy Directions guide CalMHSA in the planning and implementing of the three “Strategic Plans for California Statewide PEI Projects for Suicide Prevention, Stigma and Discrimination Reduction and Student Mental Health”. The pertinent MHSOAC PEI Principles and Policy Directions are:

- Each statewide initiative should be complementary to the other initiatives (e.g., the Suicide Prevention Initiative should address how its design complements stigma and discrimination reduction and vice versa) and should complement other state, regional and local resources.

- If a replicable program of a multi-collaborative effort is prioritized, the program should not be in the same funding priority, category or program, for example, a statewide media campaign.

- All initiatives should be inclusive of stakeholder involvement.

- All initiatives should be culturally and linguistically competent, respectful and inclusive of California’s diverse population across all age groups including seniors.

- All initiatives should have a life span appropriate focus for children, transition age youth, adults and older adults.

- All initiatives should address California’s geographical diversity, ranging from small communities spread over large rural areas to metropolitan areas with suburban expanse and urban density.

- All initiatives should optimally leverage federal, state and local resources.

- All initiatives should be achievable with four years’ funding.

- All initiatives should support data driven policy and evidence based, promising and community defined practices.
• All initiatives should improve the cultural competence and appropriateness of suicide prevention activities

• Available resources will limit the scale of implementation

• CalMHSA will implement specific prioritized recommended actions from suicide prevention and stigma and discrimination reduction as described in the work plan should additional funds be made available by counties not currently participating in the CalMHSA implementation of statewide PEI or from some other source, CalMHSA may consider implementing Recommended Actions not specified in the Work Plan. Student Mental Health Initiative will be implemented in whole.

• Expenditure of funds shall be implemented proportionately. “It is the intent of the MHSOAC that the expenditure of PEI Statewide Funds be consistent with the general proportion of funds originally intended for the three program areas identified in the DMH Information Notice No. 08-25: Suicide Prevention, 25%; Stigma and Discrimination Reduction, 37.5%; and Student Mental Health, 37.5%.”

• Funding Reversion: Pursuant to Welfare and Institutions Code Sections 5846 and 5847, as specified in DMH Information Notice 10-13: “PEI statewide programs by the MHSOAC, the three-year period for reversion of funds made available for FY 08/09, FY09/10 and FY10/11 will now begin on July 1, 2010 and end on June 30, 2013. The three year period for funds made available for FY 11/12 will begin on July 1, 2011 and end on June 30, 2014.”

**CalMHSA Statewide PEI Work Plan Development**

CalMHSA has moved implementation of the PEI plans forward through the following series of activities:

First, CalMHSA formed an Implementation Ad Hoc Committee of Board members to review the three strategic plans, gather additional stakeholder input and write a work plan for wider stakeholder review to be submitted to the MHSOAC for approval. The members of the Ad Hoc Committee functioned as advisors to the staff and consultants who wrote the work plan. The stakeholders requested increased participation in the work plan. Early in the process the Ad Hoc Committee lengthened the time for additional review and included the stakeholders in the
development of the work plan. Throughout the rest of the CalMHSA implementation process, stakeholders reviewed, advised and assisted in the process and development of the work plan.

The CalMHSA Ad Hoc Committee members were selected for their experience in community planning processes and knowledge of the mental health field. The members worked closely with staff in editing and preparing the documents as well as in presenting and reviewing the documents with stakeholders. At its August 2010 meeting, the CalMHSA Board authorized stakeholder participation in the Ad Hoc Committee meetings. These meetings are conducted by telephone conferences.

The prioritization process used for the CalMHSA Implementation Work Plan was informed by the Strategic Plans which had extensive statewide stakeholder involvement for the Suicide Prevention and Stigma and Discrimination Reduction strategic plans. Stakeholder participation in Ad Hoc Committee meetings will continue through the completion of the final CalMHSA Implementation Work Plan in November of 2010.

The procedures and considerations that the committee members and the staff used for the developing the work plan included:

- Use of the extensive stakeholder input noted in the Suicide Prevention and Stigma and Discrimination Reduction strategic plans including the referencing of the recommended actions contained in the original plans
- Review of all the most recent stakeholder input received during the 52-day input period
- Consideration of the MHSOAC guidelines for the work plan
- Acknowledgement that recommendations from representatives of organizations carry more weight than submissions from individuals
- Awareness that there is not enough resources to do all that is in the strategic plans
- Expectation that, since all funds are not available immediately, there will be at least two stages of funding
- Avoiding duplication of efforts already initiated prior to work plan development

Based on the above considerations, members of CalMHSA continued to work with staff and writers in the development of the work plan. This included creating a draft set of recommended priorities that was presented to the Ad Hoc Committee including the stakeholders on September 3, 2010. The set of recommended priorities was discussed with stakeholders, then
reviewed, revised and submitted for approval to the CalMHSA Board on September 10th. A
timeline for the work plan was also reviewed by stakeholders and submitted to the CalMHSA
Board. A key date for the work plan was set as October 7, 2010 so that it would be posted for
30-day public review prior to being submitted to the CalMHSA Board and then to the MHSOAC.

The next meeting of the Ad Hoc Committee was set for September 17th. At that time the
members and the staff presented an initial draft of the structure of the work plan. A complete
first draft of the work plan using the structure already reviewed was submitted for the Ad Hoc
Committee’s review on September 27th. The committee reconvened on October 4th to
comment and walk through the work plan and identify corrections, additions and comments.
During the Implementation Ad Hoc Committee meeting of October 4th, two additional
recommended actions were added to the Work Plan: Stigma and Discrimination Reduction 1.3
and 2.3. The work plan was posted on October 7th for 30-day public comment.

The work plan contains funding estimates for the first stage of the statewide implementation.
The second stage will occur once funds are in from all counties that join CalMHSA. The current
budget detail shows the amount allocated for Suicide Prevention (SP), Stigma and
Discrimination Reduction (SDR) and Student Mental Health Initiative (SMHI); and within each of
the initiatives, the amount allocated for each priority and program. Once the plan is approved,
Request For Proposals (RFP) will be released, containing more detailed scopes of work and
budget information.
### CalMHSA Member Counties

**JPA Name:**

**CalMHSA**

“A George Hills Company Administered JPA”

**Member Counties:**

- Butte (Anne Robin, MFT)
- Colusa (William Cornelius, PhD)
- Contra Costa (Donna M. Wigand, LCSW)
- Fresno (Donna Taylor, RN)
- Glenn (Scott Gruendl, MPA)
- Imperial (Michael W. Horn, MFT)
- Kern (James A. Waterman, PhD)
- Lake (Kristy Kelly, MFT)
- Los Angeles (Marvin J. Southard, DSW)
- Marin (Bruce Gurganus, MFT)
- Modoc (Karen Stockton, PhD, MSW)
- Monterey (Wayne Clark, PhD)
- Orange (Mark Refowitz, MSW)
- Placer (Maureen Bauman, LCSW)
- Riverside (Jerry Wengerd, LCSW)
- Sacramento (Mary Ann Bennett)
- San Bernardino (Allan Rawland, ACSW, MSW)
- San Luis Obispo (Karen Baylor, PhD, MFT)
- Santa Clara (Nancy Pena, PhD)
- Santa Cruz (Leslie Tremaine, EdD)
- Siskiyou (Michael Noda)
- Solano (Glenda Lingenfelter, RN)
- Sonoma (Michael Kennedy, MFT)
- Stanislaus (Denise Hunt, RN, MFT)
- Sutter (Brad Luz, PhD)
- Trinity (Noel O’Neill, MFT)
- Ventura (Meloney Roy, LCSW)
- Yolo (Kim Suderman, LCSW)
- Yuba (Brad Luz, PhD)

**Board Executive Committee:**

- Allan Rawland, President
- Wayne Clark, Vice President
- Maureen Bauman, Secretary
- Karen Baylor, Treasurer
- Scott Gruendl, Superior Region
- Denise Hunt, Central Area
- Michael Kennedy, Bay Area
- Mark Refowitz, Southern Region
- Marvin Southard, Los Angeles Region

**Implementation Ad Hoc Committee:**

- Wayne Clark, PhD, Committee Chair
- William Arroyo, MD
- Maureen Bauman, LCSW
- Karen Baylor, PhD
- Mary Ann Bennett
In addition to other bidders, counties, in collaboration with other counties acting as regions, that are members of the CalMHSA JPA are eligible to apply for funds to implement certain of the Recommended Actions (detailed on the following pages). Below is a list of eligible counties:

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<thead>
<tr>
<th>CalMHSA Participating Counties</th>
<th>Funding Amount Contributed</th>
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<tr>
<td>Butte</td>
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<td>Colusa</td>
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<td>Contra Costa</td>
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<td>Fresno</td>
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<td>Glenn</td>
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<td>Los Angeles</td>
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<td>Marin</td>
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<td>Modoc</td>
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<td>Monterey</td>
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<td>Riverside</td>
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<td>San Bernardino</td>
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CalMHSA Statewide Implementation Work Plans

As stated above, the Strategic Plans for Suicide Prevention, Stigma and Discrimination Reduction and the Student Mental Health Initiative are the building blocks for the Implementation Work Plans (Plans) presented below. This statewide stakeholder process provided a strong foundation from which to build the Plans. Extensive statewide stakeholder input is integrated within the Suicide Prevention and Stigma and Discrimination Reduction plans including the referencing of the recommended actions contained in the original Strategic Plans.

Section A of the CalMHSA Statewide PEI Implementation Work Plan on Suicide Prevention contains priorities, themes and recommended actions and budget information. Sections B and C provide a similar format for Stigma and Discrimination Reduction and the Student Mental Health Initiative. For a budget summary and program overview of all three initiatives, refer to Appendix 1.

Section A. CalMHSA Implementation Work Plan on Suicide Prevention

Below are the CalMHSA Statewide PEI Summary of Stigma and Discrimination Reduction priorities, themes and recommended actions. After the summary is a detailed program description, program deliverables, anticipated number of awards, scope of work, budget and evaluation information.

Priority One: Create a System of Suicide Prevention

Recommended Actions 1.3, 1.4, 1.11, 1.12 and 1.13

The purpose of the statewide Suicide Prevention Network Program (SPNP) is to serve as the focal point for statewide suicide prevention activities, establish partnerships across systems and disciplines, convene working groups, develop and disseminate resources, promote programs that reduce or eliminate service gaps to underserved racial, ethnic and cultural groups across the lifespan and implement educational, promotional and best practice strategies to prevent suicide in California.

Recommended Actions 1.5 and 1.6

The purpose of the Regional and Local Suicide Prevention Capacity-Building Program is to expand the number and capacity of accredited local suicide prevention lines, this program also requires that each suicide prevention line join a consortium of publicly funded Suicide Prevention Call Centers.
Priority Two: Educate Communities to Take Action to Prevent Suicide
Recommended Actions 3.2, 3.3, 3.7, 3.8, 3.9 and 3.11

The purpose of the Social Marketing Suicide Prevention Campaign Program is to improve the media presentation of mental illness and suicide through electronic and print media messages and media education. Electronic and print media messages and education will be disseminated to communities with the purpose of informing, educating and changing attitudes about suicide and mental health.

Priority Three: Implement Training and Workforce Enhancements to Prevent Suicide
Recommended Actions: 2.1, 2.2 and 2.5

The development of program curriculum will address professionals across systems and disciplines and also connect to the higher education Student Mental Health Initiative.

Priority Four: Improve Suicide Prevention Program Effectiveness and System Accountability
Recommended Actions: 4.2, 4.3, 4.5 and 4.6

The purpose of the Suicide Prevention Evaluation and Accountability Program is to improve data collection, surveillance and program evaluation and launch a research agenda to design responsive policies and effective programs.

Outcomes
- Reduced suicide rates in California across the age spans
- Increased capacity and improved early identification and early intervention services for consumers who are at-risk for suicidal behaviors across all age groups and diverse populations
- Increased help-seeking by and referrals for consumers and family members
- Increased capacity and improved networking capability for linkage and support in navigating service systems as needed
- Increased capacity for surveillance, research and evaluation on suicide and suicide prevention
• Improved availability, accessibility and quality of services for the historically underserved racial, ethnic and cultural groups across the age span with high suicide rates

• Expanded outreach efforts by working with tribal governments, Indian health centers, promotoraes, public health specialists, spiritual/religious leaders, state department liaisons, community-based organizations, and others

• Reduced disparities in the availability, accessibility and quality of services for historically underserved racial, ethnic and cultural groups across all age groups

• Prevention program and community services are responsible for ensuring that suicide prevention programs are participant-driven, recovery-based, trauma-informed and available to people who need them. Suicide prevention planning and intervention efforts must show evidence of:

  o Involving consumers who are at-risk for suicidal behaviors, survivors of suicide attempts, their caregivers, significant others and their friends in meaningful and appropriate ways, as they bring important personal experience and unique perspectives to identifying needs and gaps in the service delivery system

  o Involving a wide range of partners in all aspects of planning and implementation

  o A life span appropriate approach that includes consideration and involvement of children, transition age youth, including foster youth, adults and older adults

  o Culturally and linguistically appropriate suicide and mental health services, supports and resources

• Additional criteria for applicant:

  o Coordinate with Office of Suicide Prevention: Develop a comprehensive statewide assessment of existing resources and gaps. Convene a state level advisory committee and working groups to provide direction, monitor efforts and strategize for sustainability.

  o Work with the data: Intervention activities should target periods of time when surveillance data have indicated that suicide risk is high (e.g., onset of a mental
illness particularly depression and immediately after a hospital discharge).

Recognition of early signs of mental health problems, particularly depression is one of the most effective ways to prevent suicide

- Cultural differences must be considered: Disparities are evident in the scarceness of culturally and linguistically appropriate suicide and mental health services and supports, including inconsistency in language access in services, hotlines, information materials and in lack of evidence-based practices that have not been tested among diverse cultural population groups.
# California Mental Health Services Authority (CalMHSA) Suicide Prevention

Program Budget Projections (October 1, 2010)

<table>
<thead>
<tr>
<th>Suicide Prevention Project</th>
<th>Funds Assigned at Date of Submission</th>
<th>Prospective Members</th>
<th>Evaluation 7.50%</th>
<th>Enclosure F Disclosure</th>
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<td>Encl F - #4 (1)^A</td>
<td>Encl F - #4 (2)^A</td>
<td>Encl F - #5 (3)^B</td>
<td>Total (4)^C</td>
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<tr>
<td><strong>Priority 1</strong></td>
<td></td>
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<td>1,989,293</td>
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<td><strong>Priority 3</strong></td>
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<td>Effectiveness - SP 4.2, 4.3, 4.5, 4.6</td>
<td>995,823</td>
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<td><strong>Total Suicide Prevention</strong></td>
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<td><strong>2,553,946</strong></td>
<td><strong>26,561,028</strong></td>
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</table>

*See Appendix 1 for full budget information and footnotes.*
**Priority One: Suicide Prevention**

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Create a System of Suicide Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td>SP 1.3, 1.4, 1.11 and SP 1.13</td>
</tr>
<tr>
<td><strong>Program Name:</strong></td>
<td>The Suicide Prevention Network Program (SPNP)</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>The purpose of the statewide Suicide Prevention Network Program (SPNP) is to serve as the focal point for statewide suicide prevention activities, establish partnerships across systems and disciplines, convene working groups, develop and disseminate resources, promote programs that reduce or eliminate service gaps to underserved racial and ethnic populations and implement educational, promotional and best practice strategies to prevent suicide in California. This system will consist of the following four actions:</td>
</tr>
</tbody>
</table>

**Recommended Actions:**

- **SP 1.3** Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide.
- **SP 1.4** Convene and facilitate topic specific working groups that will address specific populations and issues and develop, adapt and disseminate resources and other materials that address the topics.
- **SP 1.11** Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines. Establish formal partnerships that foster communication and coordinated service
SP 1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

Priority One: Suicide Prevention

Recommended Action: SP 1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide.

Program Description
The purpose of the statewide Suicide Prevention Network Program (SPNP) is to serve as the focal point for statewide suicide prevention activities; establish partnerships across systems and disciplines, convene working groups; develop and disseminate resources; promote programs that reduce or eliminate service gaps to underserved racial and ethnic populations; and implement educational, promotional and best practice strategies to prevent suicide in California.

A statewide network will be created that will educate gatekeepers for all age groups including diverse populations, provide technical assistance to local Suicide Prevention Lines, develop age and culturally specific suicide prevention trainings and convene state and regional forums and symposiums on suicide prevention. The statewide SPNP shall employ a life span approach by engaging public and private organizations throughout the State of California.

These partnerships may include the business community, multicultural and community-based organization, gatekeepers, older adult service providers, the spiritual and faith communities, private foundations, elementary through high schools, higher education institutions, social service and juvenile justice entities and military partners such as Veterans Affairs and the National Guard. Suicide prevention planning and intervention efforts must also involve survivors of suicide attempts, their caregivers, significant others and their friends in meaningful and appropriate ways, as they bring important personal experience and unique perspectives to identifying needs and gaps in the service delivery system.
To broaden the diversity of partners involved in helping to transcend the traditional mental health system and to align with the California call to action and anti-stigma endeavor that “Every Californian is Part of the Solution,” a wide range of partners is critical, including key informants and gatekeepers from multicultural communities as representatives and as part of the leadership structure, and should be represented in all aspects of planning, implementation and evaluation process.

The goal of suicide prevention activities should be reduced suicide rates in California across the age spans resulting in a 5% reduction in suicide rates the first year. The objectives should include improving early identification, early intervention and referral for at-risk suicidal behaviors. Proposals for the SPNP shall address the following elements

- Coordinated response to crisis: To effectively prevent suicide, it is critical that each county have well-coordinated crisis response services. Suicide prevention is challenging because of the range of risk factors, the variety of settings in which suicide prevention can be implemented and supported, and its wide scope involving all age groups priority and high risk populations, particularly those that are not adequately addressed through existing programs. For example:
  - Suicide risk is significantly higher among white males (particularly middle aged and older adults), yet few resources target this population
  - Rates of suicide are highest in rural areas. The majority of California’s counties are either rural or have significant rural areas, yet smaller counties have fewer resources to address this issue than larger counties
  - National data clearly shows that Native Americans are at very high risk, particularly younger males. Although California has the highest Native population of any state, there is not sufficient data to portray the true impact of suicide
  - Rates of suicide tend to be higher among middle aged and older adults than younger age groups; additionally the majority of older adults who die by suicide have visited a physician within one month of their death
  - Reducing access to lethal means is one of a few strategies that have led to a reduction in suicides as a direct result of a particular intervention or
policy change, for example, providing caregiver education about safe storage of firearms and prescription medicines when discharging individuals at risk from institutional settings and emergency rooms.

- Coordination with the Office of Suicide Prevention: Work with the OSP to develop a comprehensive statewide assessment of existing resources and gaps to inform priorities for the next four years. Work with OSP to convene a state level Advisory Committee and work groups to provide direction, monitor efforts and strategize for sustainability.

- Working with the data: Intervention activities should target periods of time when research and surveillance data have indicated that suicide risk is high (e.g., onset of a mental illness and immediately after a hospital discharge). Recognition of early signs of mental health problems, particularly depression is one of the most effective ways to prevent suicide. Cultural differences must be considered: Disparities are evident in the scarceness of culturally and linguistically appropriate suicide and mental health services and supports, including inconsistency in language access in services, hotlines, informational materials and in lack of evidence-based practices that have not been tested among diverse cultural population groups.

Program Deliverables, SP 1.3 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Create a statewide suicide prevention network to educate gatekeepers for all age groups including diverse populations

- Engage a broad spectrum of partners, including the business community, multicultural and community-based organizations, gatekeepers, etc.

- Develop a comprehensive assessment of suicide prevention resources and gaps, including assessment of high risk populations, e.g., rural areas, white males (particularly middle aged and older adults), transition age youth and transition age foster youth, Native Americans (particularly younger males), middle-aged and older adults, etc.

- Provide technical assistance to local suicide prevention lines

- Develop culturally and age-specific suicide prevention trainings
• Convene state and regional forums and symposiums on Suicide Prevention

| Recommended Action: SP 1.4 | Convene and facilitate topic-specific working groups that will address specific populations and issues and develop, adapt and disseminate resources and other materials that address the topics. |

The purpose of the Suicide Prevention Workgroups is to address specific populations across all age groups and diverse populations and to develop, adapt and disseminate resources.

To ensure that the system for suicide prevention is effective, it is critical to create collaborative learning at multiple levels. This program would identify, develop and/or adapt educational materials, organize work groups and facilitate collaborative learning opportunities that address population-specific roles in preventing, assessing and treating suicidal behavior, including the influence of culture as it pertains to multi-level communication and influencing behavior. The statewide Suicide Prevention Workgroups Program strategies shall be guided by the “California Strategic Plan on Suicide Prevention: Every Californian is Part of the Solution” and shall address the following elements:

• Collaborative models will be developed to ensure that professionals from different disciplines and service systems that have important roles in preventing, assessing and treating suicidal behavior can communicate and coordinate their activities

• Gatekeeper models will be utilized to provide education and training in identifying the warning signs of mental health problems, assessing suicide risk and how to refer people to services that can help prevent suicide behavior

Program Deliverables, SP 1.4 (also see Appendix 2):
An RFP will be created to implement the following deliverables:

• Convene topic-specific workgroups

• Identify, develop, adapt and disseminate resources

• Organize and facilitate collaborative learning opportunities at multiple levels and across disciplines and service systems
Identify gatekeepers models to provide education and training

**Recommended Action: SP 1.11**

Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

**Recommended Action: SP 1.13**

Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.

California is a diverse state. To be effective, systems, organizations and services for suicide prevention must embrace behaviors, attitudes and policies that are compatible with diverse cultural belief systems and customs. Mental health and suicide prevention services need to identify and develop culturally appropriate outreach and engagement activities and diagnosis and treatment strategies. The purpose of the Multi-Level Outreach and Engagement Program (MLOEP) is to engage providers in suicide risks and prevention education, skills development and partnership-building activities. This program uses multi-level interventions targeted at reducing risk factors, enhancing protective factors, facilitating collaborative partnerships, promoting education and skills development, (i.e., “recognize and intervene” suicide prevention skills). A key goal is to reduce disparities in the availability, accessibility and quality of services for racial, ethnic and cultural groups across all age groups that have been historically underserved.

Providers in multiple service fields should be equipped to “recognize and intervene” when suicide risk is present. Health clinics (e.g., primary care and prenatal care), older adult service providers, mental health centers, emergency response systems, crisis centers, alcohol and drug programs, etc., are key access points. Key personnel in these systems need to have consistent guidelines and training for effective assessment and treatment interventions.

Effective approaches to suicide prevention need to include outreach and intervention strategies that specifically target historically underserved racial and ethnic groups and other at-risk populations, including transition age youth and transition age foster youth. Interventions need to be matched to relevant evidence-based, promising and best practices and new strategies that encompass the unique characteristics of different age groups and ethnic populations and the disparities in access to services.
Program Deliverables, SP 1.11 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Establish and convening the MLOEP
- Teach suicide risk “recognition and intervention” strategies and skills in a variety of personnel systems and community environments such as health clinics (e.g., primary care and prenatal care), older adult service providers, mental health centers, emergency response systems, crisis centers, alcohol and drug programs, etc.
- Facilitate collaborative learning opportunities locally and across a diversity of disciplines
- Establish and participate in formal partnerships that foster communication and coordinated service delivery among providers from different systems

Program Deliverables, SP 1.13 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Identify and develop culturally appropriate outreach, engagement, diagnosis and intervention strategies
- Implement these strategies to specifically target historically underserved racial and ethnic groups and other at-risk populations across the lifespan

Anticipated Number of Awards: To be determined when RFP is released.

Scope of Work: The Suicide Prevention Network Program (SPNP) is provided in the RFP for Recommended Actions: SP 1.3, SP 1.4, SP 1.11 and SP 1.13.

Program Budget Detail: CalMHSA will prepare budget projections for each program and line item budgets will be required for each program funded.

Program Evaluation: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
<table>
<thead>
<tr>
<th>Priority One continued</th>
<th>Create a System of Suicide Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Action: SP 1.12</strong></td>
<td>Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions; existing community-based services for older adults; employee assistance programs and the workplace; and the criminal and juvenile justice systems.</td>
</tr>
</tbody>
</table>

**Program Description**

School staff members are in a strategic position to detect the early stages of mental health problems and potential suicide risk. Mental health and suicide prevention programs that are school-based can be successful in encouraging students at risk to seek help and to follow through on referrals and to respond to a suicide crisis in a way that minimizes the chances of a contagion effect. School programs can enhance the capacity to build resiliency among students by adopting curricula that teach problem-solving skills, coping and support-seeking strategies.

Many young people who are at high risk of suicide may have already stopped attending school and/or may have contact with the juvenile justice system. It is critical to develop strategies to reach out to these individuals in areas where they congregate and through groups with which they are associated.

Increasing the availability of mental health and suicide prevention services on college campuses is an important step in preventing suicide among young adults. Prevention strategies need to be in place long before the presence of suicidal ideation or mental health crisis.

Multiple evidence-based programs have been developed that target older adults. Most of these programs contain components for outreach, engagement and education that are embedded within existing community structures and services that older adults commonly use. Other effective approaches integrate mental health services into primary care, such as co-locating health and mental health services.

Integrating suicide prevention into workplace settings is recommended to reach a large number of adults who may be at risk but not likely to seek out mental health services. Searchable databases provide resources, models, assessment tools and detailed information related to mental health issues in the workplace. Additional resources for integrating suicide prevention into workplace settings are needed, including directories of local prevention, treatment and support services, all made readily available in a non-stigmatizing manner to all employees.
Building suicide prevention and mental health into existing support networks such as employee assistance programs are effective ways to reach people who might not otherwise seek help.

Many effective programs offer models for partnership between the criminal justice and mental health systems, for example, jail diversion and re-entry programs. By building local partnerships between and within the criminal justice system and at the community level, suicide risk among inmates and parolees/probationers can be reduced along with the medical cost of treating acute problems.

**Program Deliverables, SP 1.12 (also see Appendix 2):**

Priority 1 and Recommended Action SP 1.12 are expected to support a California statewide system for suicide prevention by integrating suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace and the criminal and juvenile justice systems through program deliverables designed to:

- Increase the availability of mental health and suicide prevention services in K-12 schools
- Increase the availability of mental health and suicide prevention services on college campuses
- Increase the capacity of school programs to build resiliency among students by adopting curricula that teach problem-solving skills, coping and support-seeking strategies
- Develop strategies to reach out to those who are at high risk of suicide
- Develop peer-to-peer services for suicide prevention on college campuses
- Integrate suicide prevention into work settings for adults who may be at risk but not likely to seek out mental health services
- Develop strategies to address suicide prevention through consultation with mental health consumer, consumer groups, survivors of suicide attempts for each specific population to be served
- Develop strategies to address suicide prevention among veterans, and closely coordinate these with the statewide initiatives that are currently underway

**Anticipated Number of Awards:** To be determined when RFP is released.
Scope of Work: The scope of work will be provided in the RFP for Recommended Action SP 1.12.

Program Budget Detail: CalMHSA will prepare budget projections for each program and line item budgets will be expected for each program funded.

Program Evaluation: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
### Priority One continued

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<td><strong>Recommended Actions:</strong></td>
<td>SP 1.5, and SP 1.6</td>
</tr>
<tr>
<td><strong>Program Name:</strong></td>
<td>The Regional and Local Suicide Prevention Capacity-Building Program</td>
</tr>
</tbody>
</table>

**Purpose:**

The purpose of the Regional and Local Suicide Prevention Capacity-Building Program is to expand the number and capacity of accredited local suicide prevention lines. This program would also require that each suicide prevention line join a consortium of publicly funded Suicide Prevention call centers. This regional and local program will consist of the following 2 activities:

<table>
<thead>
<tr>
<th><strong>Recommended Actions:</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>SP 1.5</strong> Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.</td>
</tr>
<tr>
<td><strong>SP 1.6</strong> Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as websites.</td>
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</table>

**Program Description**

Suicide prevention hotlines are an effective way for people in crisis to reach out for help. Those who use lines report that they are helped by the service, while new technologies indicate that there are additional media that can be used to reach out to and communicate with those in crisis. Hotlines have been used to target prevention activities for specific populations, for example, suicide prevention programs that also offer 24-hour crisis intervention, older adult abuse prevention, grief counseling, well-being checks, etc. Several hotlines target youth and veterans. Targeted approaches are an important component of a system of suicide prevention.
that is responsive to diverse needs within communities. Targeted approaches also entail that other means of communication be explored, such as websites.

California needs to increase the capacity of suicide prevention hotlines so that callers from every county can access a local, accredited call center. A long-term commitment to continuity and quality is needed to enhance the availability and capacity, including multiple-language capacity, of suicide prevention hotlines. Hotlines that are accredited ensure that assessment procedures are completed in a thorough manner.

**Program Deliverables, SP 1.5 and SP 1.6 (also see Appendix 2):**

Priority 1 and Recommended Actions SP 1.5 and 1.6 are expected to support a California statewide system for suicide prevention by enhancing the capacity and supporting the accreditation of suicide prevention hotlines through establishment of the Regional and Local Suicide Prevention Capacity-Building Program. An RFP will be created to implement the following deliverables:

- Build capacity for local suicide prevention hotlines to become accredited
- Identify and implement strategies to expand resources and services for accredited suicide prevention hotlines, such as training centers and aftercare services
- Hotlines should target specific populations such as youth, older adults, veterans, transition age youth and transition age foster care youth, etc.
- Establish, build and maintain a statewide consortium of suicide prevention hotlines to focus on policy development and law enactment that will require accreditation as a condition of public funding for suicide prevention hotlines
- Participate in OSP statewide consortium of crisis centers
- Ensures that responders are trained in evidence-based risk assessment procedures and that these procedures are consistently administered to all callers
- All initiatives should be culturally and linguistically competent, respectful and inclusive of California’s diverse population across all age groups including seniors

**Anticipated Number of Awards:** To be determined when RFP is released.

**Scope of Work:** The Regional and Local Suicide Prevention Capacity-Building Program is provided in the RFP for Recommended Actions SP 1.5 and SP 1.6.
**Program Budget Detail:** CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

**Program Evaluation:** Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
## Priority Two: Suicide Prevention

### Theme:
Educate Communities to Take Action to Prevent Suicide

### Recommended Actions:
SP 3.2, SP 3.3 and SP 3.7

### Program Name:
Social Marketing Suicide Prevention Campaign Program (SMSPC)

### Purpose:
To raise awareness that suicide is preventable and create an environment that supports suicide prevention and help-seeking behavior.

### Recommended Actions:

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SP 3.2</strong></td>
<td>Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.</td>
</tr>
<tr>
<td><strong>SP 3.3</strong></td>
<td>Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness and mental health services that support suicide prevention efforts.</td>
</tr>
<tr>
<td><strong>SP 3.7</strong></td>
<td>Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.</td>
</tr>
</tbody>
</table>

### Program Description
The purpose of the Social Marketing Suicide Prevention Campaign Program (SMSPCP) is to raise awareness that suicide is preventable and support help-seeking behaviors by improving media presentation of mental illness and suicide through electronic and print media messages and...
through media education. Once developed, electronic and print media messages will be
disseminated to communities to educate and raise awareness about suicide risks and
prevention and mental health across the lifespan including diverse populations.

Negative portrayals of individuals with mental illness and sensational coverage of a tragic event
contribute to stigmatizing attitudes in the general public. This often leads to discrimination.
When not countered with education and awareness about the facts of mental illness, these
negative portrayals promote fear in the general public and promote self-stigma among
individuals with a mental health illness. However, media coverage is far reaching. When anti-
stigma attitudes, education and sensitivity are integrated into media coverage and messages,
public awareness is raised and the likelihood for individuals to seek help for a mental health
need or for suicide prevention support may increase when no discrimination is perceived.

National and state public health agencies have developed mechanisms to engage and educate
the entertainment industry about health promotion and disease prevention. Still, there is a
need to inform the media about how to cover suicide incidents in a way that balances public
safety with what is newsworthy. Media coverage should be used as a positive tool to promote
greater understanding of the risks and protective factors and how to get help.

A number suicide prevention education campaigns exist. The Substance Abuse and Mental
Health Services Administration (SAMHSA) provides an ongoing anti-stigma campaign with
resources provided for states to develop their own targeted anti-stigma materials. Localized
stigma and discrimination reduction projects are underway in California through MHSA funding.
In addition, national and state public health agencies have developed mechanisms to engage
and educate the entertainment industry around health promotion and disease prevention.

When anti-stigma attitudes, education and sensitivity are integrated into media coverage and
messages, public awareness is raised, and attitudes and behaviors may be modified, increasing
the likelihood for individuals to seek help for a mental health need or for suicide prevention
support.

**Program Deliverables, SP 3.2, 3.3 and 3.7 (also see Appendix 2):**

An RFP will be created to implement the following deliverables:

- Identify and implement population-specific strategies that promote suicide prevention
- Develop and implement an age-appropriate, multi-language education campaign
- Develop statewide suicide prevention education campaigns that coordinate suicide prevention and anti-stigma efforts and complement other local and national suicide prevention and anti-stigma campaigns
- Create ongoing relationships with local media contacts and local entities
- Provide media contacts with education and information about balanced messages related to the coverage of suicide
- Create ongoing relationships with local media contacts
- Provide annual retreats where representatives of the media and entertainment industry are convened for education and training
- Include local media contacts in efforts to develop suicide prevention education campaigns
- Disseminate suicide prevention-related information and resources to local media contacts and coordinate this with the Suicide Prevention Resource Center and the American Association of Suicidology guidelines for media reporting

**Anticipated Number of Awards:** To be determined when RFP is released.

**Scope of Work:** The scope of work will be provided in the RFP for Recommended Actions: SP 3.2, 3.3 and 3.7.

**Program Budget Detail:** CalMHSA will prepare budget projections for each program and line item budgets will be expected for each program funded.

**Program Evaluation:** Each CalMHSA Statewide PEI prevention applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
### Priority Two continued

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Educate Communities to Take Action to Prevent Suicide</th>
</tr>
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<tbody>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td>SP 3.8, SP 3.9 and SP 3.11</td>
</tr>
<tr>
<td><strong>Program Name:</strong></td>
<td>Social Marketing Suicide Prevention Education Program Campaign</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>The purpose of the Social Marketing Suicide Prevention Education Program Campaign (SMSPEPC) is to provide family, peer and consumer education through evidence-based population specific gatekeeper training models and to incorporate and build capacity for peer support and peer support service models. The development of program curriculum shall target professionals across systems and disciplines and may also connect with the higher education initiative. This statewide program will consist of the following three actions:</td>
</tr>
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</table>

#### Recommended Actions:

- **SP 3.8** Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and community members to recognize, appropriately respond to and refer people demonstrating acute warning signs.

- **SP 3.9** Promote and provide suicide prevention education for community gatekeepers.

- **SP 3.11** Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.
Program Description
The SMSPEPC will provide family, peer and consumer education through evidence-based, population-specific gatekeeper training models and incorporate and build capacity for peer-to-peer support service models.

Cultural and personal beliefs about suicide and mental illness, concerns about stigma and discrimination and feelings of hopelessness can dissuade people from seeking help. There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicide behaviors. Strategies that include population-specific risk factors and promote help-seeking behavior encourage people to reach out to family, friends, resources in their communities and community gatekeepers.

Gatekeepers are defined as those who come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services or whose risk factors may not be visible to health and mental health professionals. Gatekeeper training targets a broad range of people in the community, for example: school and campus health personnel, teachers and faculty, employers and supervisors, faith-based community leaders, natural community helpers (such as promotoras, traditional healers), senior center staff and other aging service providers, hospice and nursing home staff, older adult service providers, group home personnel and emergency health care personnel, including first responders.

Social support in a community of peers is especially important to vulnerable populations: across all age groups and diverse populations. Peer support models can play an essential role as part of a coordinated system by improving quality of life, reducing older adult isolation, fostering recovery and resiliency and preventing a crisis from developing. Peer support programs typically offer warm lines, programs to promote health, wellness and recovery and forums to educate the public about mental illness and mental health. Peer support and peer-operated service models are an essential tool in suicide prevention.

Program Deliverables, SP 3.8, SP 3.9 and SP 3.11 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Provide family, peer, transition age youth including foster youth and consumer education through evidence-based population-specific (by age, race, culture, ethnicity, gender and sexual orientation) gatekeeper training models that identify and implement population-specific by age, race, culture, ethnicity and gender strategies and promote gatekeeper
models as an effective strategy of reaching high risk individuals across the lifespan and within diverse populations

- Engage the expertise and experience of existing survivor, transition age youth including foster youth, peer and family support groups to build a coordinated network and develop materials to support the expansion of these groups around the state

- Identify and implement population-specific strategies that promote suicide prevention across the lifespan

- Conduct regional train-the-trainer gatekeeper training that have been effective with specific populations across the lifespan including racially, ethnically and culturally diverse communities

- Establish a partnership with the Aging Services Network in California to develop a statewide training model that is available online for health and aging service providers to increase capacity to recognize suicide risk among older adults and to provide access to information about effective interventions

- Incorporate and build capacity for peer support and peer-operated services models (e.g., peer-run crisis respite centers) for consumers of all ages and within diverse communities

- Develop a “how to” manual for sustaining survivor support groups locally, including information about funding, training and establishing 501c3 status and sustainability

**Anticipated Number of Awards:** To be determined when RFP is released.

**Scope of Work:** The SPNP scope of work will be provided in the RFP for Recommended Actions SP 3.8, SP 3.9 and SP 3.11.

**Program Budget Detail:** CalMHSA will prepare budget projections for each program and line item budgets will be expected for each program funded.

**Program Evaluation:** Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
## Priority Three

<table>
<thead>
<tr>
<th>Theme:</th>
<th>Implement Training and Workforce Enhancements to Prevent Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td>SP 2.1, SP 2.2 and SP 2.5</td>
</tr>
<tr>
<td><strong>Program Name:</strong></td>
<td>Suicide Prevention Training and Workforce Enhancement Program</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>The purpose of the Suicide Prevention Training and Workforce Enhancement Program (SPTWEP) is to develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention and follow-up care across all service providers. The development of program curriculum shall target professionals across systems and disciplines and will also connect to the higher education initiative. This program will consist of the following three actions:</td>
</tr>
</tbody>
</table>

### Recommended Actions:

- **SP 2.1** Convene expert workgroups to recommend, develop, disseminate, broadly promote and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

- **SP 2.2** Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing and graduate programs.

- **SP 2.5** Increase the priority of suicide prevention training through outreach and by disseminating, tailoring and enhancing state training guidelines as necessary to meet local needs.
Program Description

Cultural and personal beliefs about suicide and mental illness, concerns about stigma and discrimination and feelings of hopelessness can dissuade people from seeking help. There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicide behaviors. Strategies that include population-specific risk factors and promote help-seeking behavior encourage people to reach out to family, friends, resources in their communities and gatekeepers.

Effective suicide prevention strategies depend on a trained workforce and an educated public. A substantial precedent exists for establishing guidelines for training and service in selected occupations, as well developing tools for assessment of suicide risk (through the American Psychiatric Association, SAMHSA, SPRC and Suicide Prevention Lifeline, for examples). In addition, SAMHSA and the SPRC have developed materials that support the development of guidelines in campus settings.

California is a large, diverse state. To strengthen suicide prevention more needs to be known about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military service and many other factors. Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. There are gaps in knowledge about how suicide impacts certain racial and ethnic groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda needs to be established to better design responsive policies and effective programs towards reducing the impact of suicide.

Statewide suicide prevention programs, in combination with PEI priority population programs, are designed to be comprehensive in both breadth (coverage across the state) and depth (intensity in priority populations). Many of the characteristics of the PEI Priority populations (trauma exposed, stressed families, school failure, etc.) are associated with greater suicide risk and programs in these other areas will inherently address suicide prevention.

Program Deliverables SP 2.1, SP 2.2 and SP 2.5 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Develop an infrastructure to identify and respond to suicide risk
- Organize and facilitate expert workgroups to develop or identify training guidelines and curricula for distribution to service providers, including peer-to-peer support providers
- Engage mental health professional groups on how to expand the incentives and accessibility of suicide, prevention and early intervention training
• Develop and implement service and training guidelines to promote effective and consistent suicide prevention, early identification, referral, intervention and follow-up care across all service providers

• Develop program curriculum that shall target professionals across systems and disciplines

• Convene expert workgroups and convene expert panels who understand issues across the age span and within racially, ethnically and culturally diverse communities

• Assess current criteria and standards for service and training that address suicide prevention, early intervention, treatment and follow-up care

• Develop statewide standards and guidelines for specific populations and settings, including comprehensive review of existing licensing and credentialing requirements as well as existing training and education models

• Identify existing guidelines for training and services and assessment of suicide risk for available use

• Increase the availability of training guidelines that promote effective and consistent suicide prevention, early identification, referral, intervention and follow-up care across all service providers

• Develop, issue and promote guidelines and recommended training curricula

• Target professionals across systems and disciplines in their curriculum development efforts and ensure that curriculum addresses cultural and age specific needs. At a minimum, occupations selected for guidelines and curricula development and training should include:
  - Primary care providers, including physicians and mid-level practitioners
  - Community clinics and health centers
  - First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities

Social workers and other staff in older adult programs, in-home support services, adult and child protective services and foster care

Adult and juvenile system correction officers and probation and parole officers

Administrators and faculty in elementary, middle and high schools and colleges and universities

• Increase the availability of training guidelines that promote effective and consistent suicide prevention, early identification, referral, intervention and follow-up care across all service providers

• Develop and implement service and training guidelines

• Assess current criteria and standards for service and training that address suicide prevention, early intervention, treatment and follow-up care

• Develop statewide standards and guidelines for specific populations and settings

Anticipated Number of Awards: To be determined when RFP is released.

Scope of Work: The scope of work will be provided in the RFP for Recommended Actions SP 2.1, SP 2.2 and SP 2.5.

Program Budget Detail: CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

Program Evaluation: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
### Priority Four

**Theme:** Improve Suicide Prevention Program Effectiveness and System Accountability

**Recommended Actions:** SP 4.2, SP 4.3 and SP 4.5 and SP 4.6

**Program Name:** Suicide Prevention Evaluation and Accountability Program

**Purpose:** The purpose of the Suicide Prevention Evaluation and Accountability Program is to improve data collection, surveillance and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations. This program will consist of the following 4 activities:

**Recommended Actions:**

- **SP 4.2** Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

- **SP 4.3** Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

- **SP 4.5** Increase local capacity for data collection, reporting, surveillance and dissemination to
inform prevention and early intervention program development and training.

**SP 4.6** Build local capacity to evaluate suicide prevention programs, including community-based participatory research methods and use the results to make program improvements.

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**Program Description**

There is a strong need to develop a comprehensive surveillance and research agenda for California that will address gaps in knowledge and provide a lasting foundation for prevention strategies. Existing local and state data on suicide provide an incomplete picture of the true magnitude of the problem in California. There are gaps in knowledge about how suicide impacts certain racial and ethnic groups. With these substantial gaps in knowledge about how suicide impacts Californians and how to better prevent it, a research agenda needs to be established to better design responsive policies and effective programs towards reducing the impact of suicide.

Our knowledge of the impact of suicidal behavior and how to prevent it is limited by current sources of data as well as a lack of standardization in how these data are collected. The available data also suggests that the population at high risk of attempts may be very different than those at higher risk of death. There are also substantial data limitations with respect to race and ethnicity as well as lack of standardization in how deaths are recorded by medical examiners and coroners. The California Violent Death Reporting System (CalDRS) pilot project headed by the Department of Public Health offers a model by which multiple sources of standardized data are integrated to provide a much fuller picture of suicide and suicide prevention.

To strengthen suicide prevention, more needs to be known about risk and protective factors based on gender, age, disability, sexual orientation, homelessness, rural location, military service and other factors. In identifying these priority areas, culture and diversity should be widely defined. To increase knowledge on these issues, California needs to expand its capacity for surveillance, research and evaluation on suicide and suicide prevention.

**Program Deliverables, SP 4.2, 4.3, 4.5 and SP 4.6 (also see Appendix 2):**

- Develop, test and adapt evidence-based practices from community promising practices for specific populations across the lifespan and within diverse communities
• Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods

• Consumers and survivors of suicide attempts should be consulted in the development of evaluation methodologies in addition to unserved and underserved cultural groups

• Provide training and technical assistance on program evaluation to the counties and local partners

• Develop methodologies to promote the evaluation of promising community-based models to build their evidence base

• Increase local capacity for data collection, reporting, surveillance and dissemination

• Improve data collection, surveillance and reporting to better understand specific populations, suicide trends and the impact of protective factors and risk factor in diverse populations across all age groups

• Build local capacity to evaluate suicide prevention programs, including community-based participatory research methods

• Provide technical assistance for the development of evaluation activities that support the scopes of work of CalMHSA providers and organizations

These actions shall be included in a statewide evaluation RFP with expectations of data collection for each program.

**Anticipated Number of Awards**: To be determined when RFP is released.

**Scope of Work**: The scope of work will be provided in the RFP for Recommended Actions SP 4.2, 4.2, 4.3, 4.5 and SP 4.6.

**Program Budget Detail**: CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

**Program Evaluation**: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
Section B. CalMHSA Implementation Work Plan on Stigma and Discrimination Reduction

Below are the CalMHSA Statewide PEI Summary of Stigma and Discrimination Reduction with “recommended actions” identified by priorities, themes and actions. After the summary is a detailed program description, scope of work, budget and evaluation information.

A set of “Core Principles” were at the forefront of the original “California Strategic Plan on Reducing Mental Health Stigma and Discrimination”. Several of these should be noted and incorporated when addressing all the recommended actions:

- Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.
- Employ a life-span approach to effectively meet the needs of different age groups.
- Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experience mental health challenges comes from voluntary programs that offer choice and options.

**Priority One: Create a supportive environment for consumers, family and others that crosses a lifespan focus**

**Recommended Actions: SDR 1.1, SDR 1.3, SDR 1.5, SDR 1.6 and SDR 1.7**

Create a supportive environment for all consumers and those at risk for mental health challenges, family members, school and campus personnel and the community at large, establishing social norms that recognize mental health is integral to everyone’s well-being.

**Priority Two: Promote awareness, accountability and change**

**Recommended Actions: SDR 2.1, SDR 2.3, SDR 2.4, SDR 2.6, SDR 2.9 and SDR 2.10**

Promote awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

**Priority Three: Increase knowledge of effective and promising programs that reduce stigma**

**Recommended Action: SDR 4.1**

Increase knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.
Priority Four: Uphold and advance federal and state laws to support the elimination of discriminatory practices

Recommended Actions: SDR 3.1 and 3.4

Uphold and advance federal and state laws to identify and eliminate discriminatory policies and practices.
California Mental Health Services Authority (CalMHSA) Program Budget

Projections (as of October 1, 2010)
Total for CalMHSA Stigma and Discrimination Reduction

<table>
<thead>
<tr>
<th>Stigma and Discrimination Reduction Project</th>
<th>Funds Assigned At Date of Submission Encl F - #4 (1)^A</th>
<th>Prospective Members Encl F - #4 (2)^A</th>
<th>Evaluation 7.50% Encl F - #5 (3)^B</th>
<th>Enclosure F Disclosure Total (4)^C</th>
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<tr>
<td>Priority 1</td>
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<tr>
<td>CSDRP-SDR 1.1, 1.3, 1.5, 1.6, 1.7</td>
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<td>1,605,154</td>
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<td>Awareness-SDR-2.1, 2.3, 2.4, 2.6, 2.9, 2.10</td>
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<td>Increase Knowledge-SDR 4.1</td>
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<td>3,213,908</td>
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<td>Priority 4</td>
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<tr>
<td>Regs Laws-SDR 3.1, 3.4</td>
<td>2,860,344</td>
<td>17,443</td>
<td>310,304</td>
<td>3,188,091</td>
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<tr>
<td><strong>Total Stigma (SDR)</strong></td>
<td><strong>35,312,886</strong></td>
<td><strong>697,738</strong></td>
<td><strong>3,830,916</strong></td>
<td><strong>39,841,540</strong></td>
</tr>
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</table>

See Appendix 1 for full budget information and footnotes.
### Priority One: Stigma and Discrimination Reduction

<table>
<thead>
<tr>
<th>Theme</th>
<th>Create a supportive environment for all consumers and their families as well as the communities where they live</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td>SDR 1.1, SDR 1.3, SDR 1.5, SDR 1.6 and SDR 1.7</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>The purpose of the mental health well-being initiative is to create a supportive environment for all consumers and those at risk for mental health challenges, family members and the community at large, establishing social norms that recognize mental health is integral to everyone’s well-being. This program will consist of the following four actions:</td>
</tr>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>SDR 1.1</strong></td>
<td>Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery.</td>
</tr>
<tr>
<td><strong>SDR 1.3</strong></td>
<td>Create opportunities and forums for strengthening relationships between consumers, family members and the larger community.</td>
</tr>
<tr>
<td><strong>SDR 1.5</strong></td>
<td>Recognize peer run and peer led programs as an important means for reducing stigma.</td>
</tr>
<tr>
<td><strong>SDR 1.6</strong></td>
<td>Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.</td>
</tr>
<tr>
<td><strong>SDR 1.7</strong></td>
<td>Provide increased support for those closely involved with the lives of individuals facing mental health challenges.</td>
</tr>
</tbody>
</table>
**Program Description**

California, according to 2007 estimates is 44 percent Caucasian, 36 percent Hispanic, 12 percent Asian and 6 percent African American, with Native Americans and Pacific Islanders each making up less than 1 percent of the population.\(^1\)

Over the years, anti-stigma campaigns have assessed that education alone is not enough. Many campaigns have become multi-faceted by involving all the necessary system levels to create individual attitude and behavior change (and includes efforts to change policies and laws) and by involving individuals with mental health challenges at all program levels. This Social Ecological Framework is used in public health for program planning. It allows for a comprehensive mapping of strategies to ensure that multiple risk factors and different social structures that influence individual behavior are influenced or changed. Communication for Social Change procedures are complementary to a Social Ecological Framework, and involves the consumer and other stakeholders in defining who they are, what their needs are, and how best the needs might be addressed and implemented.

Stigmatization of people with mental health disorders has persisted throughout history. It is manifested by distrust, bias, stereotyping, fear, embarrassment and/or avoidance. Stigma leads others to avoid living, socializing or working with, renting to, or employing people with mental health disorders, especially severe disorders such as schizophrenia. Stigmatization reduces access to resources and opportunities and leads to low self esteem, isolation and hopelessness (U.S. Surgeon General, 1999).

Discrimination occurs when people and societies act upon their feelings of rejection and discomfort with mental disability by depriving those associated with it the rights and life opportunities that are afforded to all other people. Discrimination is manifested when individuals are deprived of housing, educational, employment and so many other opportunities based on mental, social, emotional and/or behavioral impairments.

Many individuals, families, and communities experience the burden of multiple stigmas and discrimination based on race, ethnicity, and other factors that affect their ability to access and receive appropriate mental health services. This prejudice and discrimination is stressful and also affects physical and mental health. Despite experiencing multiple stigmas, some racial and ethnic communities may have certain culturally protective factors that can help counter stigma and the stresses of mental health conditions.

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The strategic directions and recommended actions of CalMHSA embrace the vision of wellness and recovery as the cornerstone to eliminating stigma and discrimination and are guided by the “California Strategic Plan on Reducing Mental Health Stigma and Discrimination” developed by the Department of Mental Health.²

The purpose of this program is to create a supportive environment for all consumers and those at risk for mental health challenges and for family and community members, establishing social norms that recognize mental health is integral to everyone’s well-being. Anti-stigma programs create widespread understanding and recognition within the public and across all systems.

Program Deliverables, SDR 1.1, 1.3, 1.5, 1.6 and SDR 1.7 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

- Form a statewide presence of local coalitions of diverse representatives, including those with mental health challenges
- Launch a community action plan that addresses education and focuses on changing attitudes and behaviors
- Develop messages and relevant materials for the public that explain mental health challenges and promote social inclusion across the lifespan and within racially, ethnically and culturally diverse populations
- Assess existing print and electronic media about mental health challenges and emotional disturbances
- Improve consumer-driven information to reflect and reinforce recovery, resilience and wellness
- Promote the development of informative and accurate Web resources
- Rely on mental health consumers and family members to raise awareness of the importance of mental health across the lifespan

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• Confront stigmatizing messages and identify how everyday language reinforces stigma and discrimination

• Develop electronic and print media to counter stigma and discrimination

Programs that provide peer-run and peer-led programs are an important means for reducing stigma. Program interventions will utilize a lifespan approach and address the following:

• Assess, develop and disseminate information on peer-run and peer-led programs and social support models

• Work with local and statewide organizations to promote coordinated message topics and the timelines for delivery

• Develop statewide support for local speaker bureaus, presentations and forums that feature peers from across the lifespan and diverse populations

• Promote education and skill-based training (attitude and behavior change) for consumer and family empowerment

• Utilize technology to support groups or individuals who are geographically or emotionally isolated

• Enhance the skills of peers to be more effective trainers of mental health staff

• Create training and advancement opportunities for individuals working to reduce stigma and discrimination

• Develop and coordinate a peer-to-peer network of support for veterans with California National Guard and Veteran organizations

Programs will address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases, with efforts to:

• Disseminate successful models for reducing stigma and discrimination that have been identified by cultural communities

• Work with consumers from the target population to ensure age and generational relevance
• Work with racial and ethnic communities groups to ensure cultural relevance and to eliminate stigmatizing barriers

• Work with racial and ethnic community groups to identify and strengthen culturally protective factors that can help counter stigma and the stresses of mental health conditions.

• Educate and address attitude and behavior change strategies for substance abuse providers and mental health providers

• Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases

Applicants will address increased support for those closely involved with the lives of individuals facing mental health challenges, with efforts to:

• Apply innovative information technologies that will allow parents, foster parents and caregivers to obtain accurate information, guidance and referrals to seek needed services

• Identify non-traditional community locations to distribute information on available mental health resources for populations across the lifespan and in underserved ethnic, racial and cultural populations

**Anticipated Number of Awards:** To be determined when RFP is released.

**Scope of Work:** The scope of work will be provided in the RFP for Recommended Actions SDR 1.1, SDR 1.3, SDR 1.5, SDR 1.6 and SDR 1.7.

**Program Budget Detail:** CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

**Program Evaluation:** Each CalMHSA Statewide PEI prevention program shall propose how and with what methods it will evaluate its effectiveness and outcomes. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
<table>
<thead>
<tr>
<th>Priority Two: Stigma and Discrimination Reduction</th>
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<tbody>
<tr>
<td><strong>Theme:</strong></td>
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<tr>
<td><strong>Recommended Actions:</strong></td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
</tr>
</tbody>
</table>

**Recommended Actions:**

- **SDR 2.1** Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices and policies.

- **SDR 2.3** Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.

- **SDR 2.4** Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.

- **SDR 2.6** Educate employers on the importance of mental health wellness for all employees.

- **SDR 2.9** Engage and educate the commercial, ethnic, public/ community and interactive media, as
well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate anti-stigma information to the public on mental health issues and community resources.

SDR 2.10 Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance.

Program Description

Stigma and discrimination occur in our schools and communities and workplace environments. From the 1950’s to the 1990’s, the percentage of Americans who viewed individuals with mental health challenges as dangerous nearly doubled. The purpose of this program is to promote awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

Anti-stigma and discrimination activities should be designed to engage and educate groups on standards and guidelines to promote balanced messages and portrayals of people living with mental health challenges. Creating an anti-stigma campaign to highlights that everyone at some point may experience some degree of mental health challenges, or developing strategies to reward balanced portrayals of individuals living with mental health challenges, are some examples of balanced messages.

To promote and enhance anti-stigma and discrimination initiatives, programs and curricula development activities that integrate mental health topics within health education and other classroom curricula; or develop support groups and systems for children and siblings of consumers experiencing mental health challenges; or encourage local mental health units to work with educational institutions to develop prevention and early intervention techniques as

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alternatives to fail-first initiatives for children and youth experiencing mental health challenges; or training programs for teachers to work more effectively with student mental health issues.

Most individuals seek primary care services a few times a year, providing primary care providers with numerous opportunities to identify behavioral health problems early and intervene in a manner that prevents further distress and avoids significant future costs. People can reduce their risk of developing a major medical illness, receive more effective treatment, and reduce their health care costs when they seek treatment from an interdisciplinary primary care team including behavioral and mental health care providers.

**Program Deliverables, SDR 2.1, 2.3, 2.4, 2.6, 2.9, SDR 2.10 (also see Appendix 2):**

An RFP will be created to implement the following deliverables:

- Support ethnic diversity, cultural competency and age appropriate training
- Train mental health and system partner staff on stigma and discrimination reduction
- Support training for mental health and system partner staff and staff of system partners that serve populations across the lifespan and underserved ethnic, racial and cultural communities

To create a more holistic and integrated approach to physical health and mental wellness, applicants might:

- Sponsor local and statewide programs to support medical practitioners
- Screen for and address both mental and medical needs of individuals entering a mental health facility
- Screen for and address both mental and medical needs of individuals entering a mental health facility
- Train providers on the value of spirituality and cultural competence in the wellness and recovery process
- Educate employers on the importance of mental health wellness for all employees
- Engage and educate the commercial, ethnic, public/community and interactive media, as well as the entertainment industry about the importance of mental health wellness
• Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance

**Anticipated Number of Awards:** To be determined when RFP is released.

**Scope of Work:** The scope of work will be provided in the RFP for Recommended Actions SDR 2.1, 2.3, 2.4, 2.6, 2.9 and SDR 2.10.

**Program Budget Detail:** CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

**Program Evaluation:** Each CalMHSA Statewide PEI prevention program shall propose how and with what methods it will evaluate its effectiveness and outcomes. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.
Priority Three: Stigma and Discrimination Reduction

Theme: Increase knowledge of effective and promising programs that reduce stigma

Recommended Action: SDR 4.1

Purpose: The purpose of this program is to increase knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

Recommended Action: SDR 4.1 Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination to build effective and promising anti-discrimination programs.

Program Description
There is a wealth of research and evaluation findings to establish what methods or combination of methods will best aid in reducing stigma and discrimination and are inclusive of community-led approaches. The purpose of this program is to increase knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led programs.

Program Deliverable, SDR 4.1 (also see Appendix 2):
An RFP will be created to implement the following deliverables:

- Develop incentives to build partnerships between academic research and community-based research
- Provide assistance to counties in developing anti-stigma and anti-discrimination programs
- Utilize multi-disciplinary research techniques to guide research on the diversity of forms of mental health stigma and discrimination
- Identify research techniques for the evaluation of anti-stigma programs for local use
Anticipated Number of Awards:  To be determined when RFP is released.

Scope of Work: The scope of work will be provided in the RFP for Recommended Actions SDR 4.1.

Program Budget Detail: CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

Program Evaluation: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. Detailed evaluation information is provided in Appendix 2.
## Priority Four: Stigma and Discrimination Reduction

<table>
<thead>
<tr>
<th><strong>Theme:</strong></th>
<th>Uphold and advance federal and state laws to support the elimination of discriminatory practices</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommended Actions:</strong></td>
<td>SDR 3.1 and SDR 3.4</td>
</tr>
<tr>
<td><strong>Purpose:</strong></td>
<td>The purpose of this program is to uphold and advance federal and state laws to identify and eliminate discriminatory policies and practices. This program will consist of the following two actions:</td>
</tr>
<tr>
<td><strong>Recommended actions:</strong></td>
<td></td>
</tr>
</tbody>
</table>

**SDR 3.1**
Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.

**SDR 3.4**
Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.

### Program Description

The United States has various powerful anti-discrimination laws, including the Fair Housing Act and the Americans with Disabilities Act. Additional systemic methods used for determining if existing laws, policies or procedures are complied with or enforced. Program areas that applicants may consider include the following:

- Increasing awareness and understanding of existing laws and policies by developing and widely disseminating user-friendly fact sheets with contact information for education and training purposes
- Reviewing federal and state regulations that support mental health services in non-traditional settings to reduce stigma
• Developing policies and mechanisms within the juvenile and criminal justice system to more appropriately meet the needs of individuals with mental health challenges by promoting mental health courts and other alternatives to incarceration

• Disseminating court policies and protocols developed by the Judicial Council of California and the Administrative Office of the Courts

• Training law enforcement and juvenile and criminal justice officials to recognize and prosecute mental health discrimination.

Program Deliverable, SDR 3.1 and SDR 3.4 (also see Appendix 2):

An RFP will be created to implement the following deliverables:

• Review federal and state regulations that support mental health services in non-traditional settings to reduce stigma

• Assess if existing laws, policies or procedures are complied with, or enforced

• Identify situations and circumstances where improvement is needed in enforcement of anti-discrimination laws and regulations

• Increase awareness and understanding of existing anti-discrimination laws and policies

• Widely disseminate age appropriate user-friendly fact sheets with contact information for education and training purposes

Anticipated Number of Awards: To be determined when RFP is released.

Scope of Work: The scope of work will be provided in the RFP for Recommended Actions SDR 3.1 and SDR 3.4.

Program Budget Detail: CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

Program Evaluation: Each CalMHSA Statewide PEI prevention program applicant shall propose how and with what methods it will evaluate its effectiveness and outcomes. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. Detailed evaluation information is provided in Appendix 2.
Section C. CalMHSA Implementation Work Plan on the Student Mental Health Initiative

The Plan for the Student Mental Health Initiative (SMHI) contains recommended actions that complement each other so well that they are not prioritized. Instead, it is planned for all actions to be implemented. The format below is tailored for the SMHI and is somewhat different than the formats in the previous sections for Suicide Prevention (SP) and Stigma and Discrimination Reduction (SDR). Included however, are theme and priority, recommended actions, scope of work, program deliverables, budget and evaluation details.

Another distinguishing factor for the SMHI is the separation of initiatives for Higher Education (with subdivisions for University of California (UC), California State University (CSU) and California Community Colleges (CCC) and Kindergarten – 12th grade (K-12), with recommended allocations of approximately 60/40 percent ratio.
California Mental Health Services Authority (CalMHSA) Program Budget

Total for CalMHSA Student Mental Health Initiative Projections (as of October 1, 2010)

<table>
<thead>
<tr>
<th>Student Mental Health Initiative Project</th>
<th>Funds Assigned At Date Of Submission Encl F - #4 (1)^A</th>
<th>Prospective Members Encl F - #4 (2)^A</th>
<th>Evaluation 7.50% Encl F - #5 (3)^B</th>
<th>Enclosure F Disclosure Total (4)^C</th>
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<tbody>
<tr>
<td>Priorities 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UC-SMHI Higher Ed 1, 2, 3</td>
<td>6,674,069</td>
<td>131,871</td>
<td>724,043</td>
<td>7,529,983</td>
</tr>
<tr>
<td>CSU-SMHI Higher Ed 1, 2, 3</td>
<td>6,674,069</td>
<td>131,871</td>
<td>724,043</td>
<td>7,529,983</td>
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<tr>
<td>CCO-SMHI Higher Ed 1, 2, 3</td>
<td>6,674,069</td>
<td>131,871</td>
<td>724,043</td>
<td>7,529,983</td>
</tr>
<tr>
<td><strong>Total Higher Education Allocation (56.7%)</strong></td>
<td><strong>20,022,207</strong></td>
<td><strong>395,613</strong></td>
<td><strong>2,172,129</strong></td>
<td><strong>22,589,949</strong></td>
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<tr>
<td>Priorities 2</td>
<td></td>
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<tr>
<td>State K-12 SMHI 4</td>
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<td></td>
<td></td>
<td>1,000,000</td>
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<tr>
<td>Regional K-12 SMHI 1, 2, 3, 4</td>
<td>14,290,660</td>
<td>302,145</td>
<td>1,658,790</td>
<td>16,251,595</td>
</tr>
<tr>
<td><strong>Total K-12 Education (43.3%)</strong></td>
<td><strong>15,290,660</strong></td>
<td><strong>302,145</strong></td>
<td><strong>1,658,790</strong></td>
<td><strong>17,251,595</strong></td>
</tr>
<tr>
<td><strong>Total Student Mental Health Initiative</strong></td>
<td><strong>35,312,867</strong></td>
<td><strong>697,758</strong></td>
<td><strong>3,830,919</strong></td>
<td><strong>39,841,544</strong></td>
</tr>
</tbody>
</table>

*See Appendix 1 for full budget information and footnotes.*
Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention

The purpose of the University and College Student Mental Health Program (UCSMHP) is to implement training, peer-to-peer support and suicide prevention within each of the three California higher education systems: University of California (UC), California State University (CSU) and California Community Colleges (CCC).

The UCSMHP will emphasize age specific, culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention plans and/or community services and supports plans and collaboration with mental health and substance abuse prevention partners.

The UCSMHPs will be established in each of the higher education systems, UC, CSU and CCU and will develop the following program components:

- Programs within each system will be designed according to the goals and values stated in the SMHI strategic plan key directions for training, peer-to-peer support and suicide prevention. Student mental health programs will be implemented to complement the two other strategic initiatives: Stigma and Discrimination Reduction and Suicide Prevention
- Establish a formal process with county mental health for ongoing collaboration
- Current data and studies about student MH should be used to inform SMHI implementation and prioritization of projects by the higher education systems
- Leverage resources and build on existing models and programs (e.g., bring to scale the currently funded CCC three campus pilot project), consistent with Stigma and Discrimination Reduction (SDR) 1.3, 1.4, 1.5 and 2.1
- Coordinate program with local speakers bureaus, veterans peer support, California National Guard and Department of Veterans affairs, consumer and family organizations and community-based cultural/ethnicity-focused organizations
- Employ established models for integrated crisis intervention with first responders such as QPR and CIT
• Locate mental health services in non-traditional settings such as primary care and student health centers, etc.

Below is the CalMHSA Statewide PEI Summary of the Student Mental Health Initiative for Higher Education, “recommended actions” identified by priorities, themes and actions. Following the summary is a detailed budget, program description, scope of work, budget (Appendix 1) and evaluation information (Appendix 2).

Higher Education

It is the intent of the MHSAOAC that programs will be established in each of the three public higher education systems: UC, CSU and CCC. Any college, district, multi-campus collaborative or system within each of the three California public higher education systems would be eligible.

These systems shall design and administer programs that will focus on three key strategic directions: training, peer-to-peer support activities and suicide prevention. Applicants are strongly encouraged to target unserved and underserved (e.g., Asian American students, LGBTQ students, international students, first generation college students, students with disabilities, and other unserved populations).

**Recommended Actions:**

| 1. Training | The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health, wellness on college campuses, and an understanding of the disability and legal rights of students with mental illness. The training would be designed to improve recognition and responses to students experiencing mental distress, to increase awareness of the disability and legal rights of students with mental illness, to reduce stigma and discrimination against persons who become identified with mental illness and to promote a campus environment that enhances student success providing hope, supporting resiliency and creating a healthy learning community. Individuals who are bilingual and ethnically diverse, and who identify as LGBTI should be trained. The training should have a component on cultural sensitivity so that trainees will be better able to identify and assess for stressors that can impact the mental health of students in higher education. |

2. **Peer-to-Peer Support**

   These activities would focus on mutual support, student retention, promoting acceptance of cultural diversity, disability, empowerment strategies and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, sexual assault and acquaintance rape, academic performance and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves. Peers with experience accessing mental health services would be beneficial. Peers who are ethnically or culturally diverse or who identify as LGBTI may provide effective support to students who are diverse.

3. **Suicide Prevention**

   These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.

**Scope of Work:** The scope of work will be provided in the RFP for Recommended Action SMHI 1.

**Program Deliverables:** Programs will focus on three key strategic directions: training, peer-to-peer support activities and suicide prevention and provide:

- Mental health and wellness training activities for students, transition age youth including foster care youth, faculty, staff and administrators

- Peer-to-peer support activities that focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies and reduction of the stigma associated with mental illness
- Suicide prevention programs that utilize the resources and best-practices of the MHSA suicide prevention efforts and bring suicide prevention resources directly onto campuses

**Program Evaluation:** The evaluation of University and College Student Mental Health Program (UCSMHP) will cover both performance and outcome measures. Outcome reviews may evaluate increased knowledge of suicide or its risk indicators, reduced incidents of suicide or suicide attempts, reduced stigma and discrimination, increased access to services, increased linkages with community resources, reduced disparities in access to services, and students’ own satisfaction with access and care. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.

**Theme and Priority: Kindergarten – Twelfth Grade Training, Peer-to-Peer Support and Suicide Prevention**

The purpose of the Kindergarten to Twelfth Grade Student Mental Health Program (K-12 SMHP) is to provide school-based programs, systems and policy developments, education and training

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**Quick Facts:**

- There are 6.25 million students in California (Source: California Department of Education, Educational Demographics Office (CBEDS, 7/27/09)
- There are 1,043 districts in California
- There are 58 County Superintendents in California
- 53 County Superintendents are elected; 5 are appointed
- Appointed County Superintendents include: Los Angeles, Sacramento, San Diego, San Francisco and Santa Clara
- There are 7 single district counties in the state: Alpine, Amador, Del Norte, Mariposa, Plumas, San Francisco and Sierra

Source: CCSESA. REVISED: December 31, 2009)
and technical assistance in schools districts. The long-term goal is that programs will be established in each of California's eleven superintendent regions. Programs within each region will be designed according to the goals and values stated in the SMH strategic plan key directions for school-based programs: systems and policy developments, education and training and technical assistance.

Initial implementation of the K-12 SMHP may include establishing demonstration programs throughout the eleven County Superintendent of Schools superintendent regions to demonstrate effective and efficient models for adaptation in other regions. California’s 58 County Superintendents of Schools and their respective county offices of education support the financial and academic stability of every district and school in the state. Their primary aim is to work collaboratively with school districts to ensure that every student benefits from a quality educational experience, regardless of their circumstances.

The California County Superintendents Educational Services Association (CCSESA) provides the organizational mechanism for the 58 County Superintendents of schools to design and implement statewide programs to identify and promote quality cost-effective educational practices and services and provide support to school districts in the areas of student services, curriculum and instructional services, fiscal accountability and business services and technology and telecommunications.

<table>
<thead>
<tr>
<th>Counties Served within the County Superintendents' Regions</th>
<th>Profiles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Del Norte, Humboldt, Lake, Mendocino, Sonoma</td>
<td>Region 1</td>
</tr>
<tr>
<td>Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama, Trinity</td>
<td>Region 2</td>
</tr>
<tr>
<td>Alpine, Colusa, El Dorado, Placer, Nevada, Sacramento, Sierra, Sutter, Yolo, Yuba</td>
<td>Region 3</td>
</tr>
<tr>
<td>Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Solano</td>
<td>Region 4</td>
</tr>
<tr>
<td>Monterey, San Benito, Santa Clara, Santa Cruz</td>
<td>Region 5</td>
</tr>
<tr>
<td>Amador, Calaveras, San Joaquin, Stanislaus, Tuolumne</td>
<td>Region 6</td>
</tr>
<tr>
<td>Kings, Fresno, Madera, Mariposa, Merced, Tulare</td>
<td>Region 7</td>
</tr>
<tr>
<td>Kern, San Luis Obispo, Santa Barbara, Ventura</td>
<td>Region 8</td>
</tr>
<tr>
<td>Imperial, Orange, San Diego</td>
<td>Region 9</td>
</tr>
<tr>
<td>Inyo, Mono, Riverside, San Bernardino</td>
<td>Region 10</td>
</tr>
<tr>
<td>Los Angeles</td>
<td>Region 11</td>
</tr>
</tbody>
</table>

The Statewide K-12 Program: Responsibility for statewide systems and policy development

The Statewide K-12 Program will include establishing and sustaining an infrastructure for addressing systems and policy issues across regional programs. A statewide infrastructure would include a big picture, advisory body that may convene and staff a “Student Mental Health Policy Workgroup” that includes high level representation from, at a minimum, the Department of Mental Health, Department of Education, County Mental Health, key school districts, key mental health provider agencies, key mental health provider agencies who serve individuals who are ethnically and culturally diverse individuals, or who identify as LGBTI, and key advocacy groups related to school health, children’s mental health and special education. The staffing for this group shall provide expertise in the financing of children’s and school mental health, including special education.

The policy work group shall identify policy changes that would facilitate sustainable funding and ongoing implementation of a comprehensive system. In addition, the policy work group would establish a system to provide ongoing statewide coordination of K-12 programs across the Superintendent Regions. Successful applicants will demonstrate the capability to design and administer programs that address the systemic challenges in providing a culturally appropriate, comprehensive approach to student mental health and well-being.

The Regional K-12 Program: Responsibility for school-based programs, technical assistance and education and training across regional programs

The School-Based Programs will provide a continuum of prevention and early intervention services including: mental health educational programs for students that include a focus on suicide reduction, incorporate age-appropriate, racial/ethnic and culturally appropriate suicide prevention training for the general student population and are in alignment with state Health Education Standards. Training should include how discrimination or bias toward ethnically and culturally diverse students or students who identify as LGBTI can result in injurious and harmful consequences.

Linkages to services that support an enhanced role for school-based health centers in offering and/or providing referrals to behavioral health services, that support partnerships between school systems and county mental health departments and community-based primary care provider and that identify and publicize where students can be referred within their community for services will be critical to accomplishing the goals of this initiative. Linkages to services provided on campus or otherwise, will be provided through school health centers, county departments of mental health, special education programs, pediatric clinics and community-based organizations. Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for
specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and females, LGBTQ youth and Native American youth.

Linkages to services should be inclusive of county/local School Attendance Review Boards (SARBs) pursuant to Education Code Section 48321. County/local SARBs provide critical prevention and early intervention services for students with serious attendance and behavior problems by identifying them and implementing ways to divert them from the juvenile justice system and ways to reduce the number of dropouts in the state public education system. Mental health representatives on SARBs add expertise and resources for high-risk students.

**Technical Assistance:** Programs may provide technical assistance through a qualified intermediary that can bring together expertise through contracts with various organizations based on the needs of the funded programs.

**Education and Training:** This component should be designed in conjunction with the school-based program. The technical assistance process can inform ongoing planning for school staff education and training.

**Theme and Priority: School-Based Programs, Systems and Policy Developments and Education and Training**

Successful applicants will demonstrate the capability to design and administer programs that address the systemic challenges in providing a comprehensive approach to student mental health and well-being. School-based mental health interventions and programs that have been proven effective shall be identified and combined into a comprehensive student mental health program.

**Recommended Actions**

<table>
<thead>
<tr>
<th>1. School-Based Programs</th>
<th>Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Efforts that foster supportive school climates including bullying prevention, suicide prevention, stigma reduction and cultural awareness</td>
</tr>
<tr>
<td></td>
<td>• Mental health educational programs for students that include a focus on stigma reduction, incorporate age-appropriate suicide prevention training for the general student population and are in alignment with state Health Education Standards;</td>
</tr>
</tbody>
</table>
and collaboration with the California Department of Education and other agencies involved in enforcing and implementing these standards to influence the curriculum to ensure that it incorporates recovery and resiliency principles

- Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps

- Collaboration with community-based providers that enhance student success, for example, health services, tutoring, afterschool programs and mentoring

- Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers

- Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs and community-based organizations. Linkages should include community-based organizations who serve ethnically and culturally diverse, and LGBTQI individuals

- Outreach and education that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services for families

- Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and females, LGBTQ youth and Native American youth
- Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral and non-stigmatizing responses.

- Use of appropriate youth peer-to-peer strategies

### 2. Systems and Policy Developments

Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:

- Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.

- Development of relationships between school systems, foster care systems, county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.

- Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.

- Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.

- Procedures for ongoing assessment of student mental health and continuous improvement of school-based programs.

- Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech-language therapists and audiologists, front line staff,
resource specialists and school nurses where available, in the planning and executing of systems and policy changes.

- Meet current state curriculum mandates for health and wellness.

3. **Education and Training**

   School/district personnel should receive education and training to support the successful implementation of specific school-based programs as well as the systems and policy changes needed to sustain these programs. State level activities for training will involve developing or enhancing existing evidence-based trainings to be more culturally and linguistically appropriate for our diverse state. This would allow schools or other community organizations to implement the training at the local level.

4. **Technical Assistance**

   In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned and access to on-site consultation to increase the effectiveness of SMHI-funded programs.

**Scope of Work:** The scope of work will be provided in the RFP for Recommended Action SMHI 2.

**Program Deliverables:**

- A statewide advisory body that convenes and staffs a “Student Mental Health Policy Workgroup”, oversees statewide coordination of K-12 programs across the Superintendent Regions and advises on development of the SMHI for K-12.

- A Regional K-12th Grade Program, responsible for school-based programs, technical assistance, education and training across regional programs.

- School-Based Grant Programs that provide a continuum of prevention and early intervention services including:
o Linkages to services provided on campus or otherwise provided through school health centers, foster care systems serving transition age youth, county departments of mental health, special education programs and community-based organizations

o Linkages to services that are inclusive of county/local School Attendance Review Boards (SARBs) pursuant to Education Code Section 48321 as mental health representatives add expertise and resources for high-risk students

o Use of appropriate youth peer-to-peer strategies: School-based peer-to-peer programs that include combinations of campus-based and the use of online tools

- Technical assistance to bring together expertise with various organizations and to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned and access to on-site consultation to Education and Training, designed in conjunction with the school-based program for ongoing planning for school staff education and training

**Program Budget Detail:** CalMHSA prepares budget projections for each program. Line item budgets will be expected for each program funded.

**Program Evaluation:** The evaluation of the Student Mental Health Initiative will cover both performance and outcome measures. Outcome reviews may evaluate increased school success, decreased school drop-out rates, reduced school suspensions and expulsions for behavior problems, increased identification of early signs of mental illness, reduced stigma and discrimination related to mental health, increased access to services, increased linkages with community resources, increase in parent or student awareness of available support resources and students’ or families’ satisfaction with care. For Program Deliverables and Indicators/Outcomes, refer to Appendix 2.

The UCSMHP and K-12 SMHP shall propose how and with what methods it will evaluate its effectiveness and outcomes. Also, each program will provide data for the statewide evaluation that will include at least baseline information on suicide incidence and prevalence. Ultimately each program will comply with data requests for the statewide evaluation of all CalMHSA-administered programs. Detailed evaluation information is provided in Appendix 2.
Appendices

1. PEI Statewide Program Funding Request
   - Budget Form – Enclosure F and F-2
   - Budget Form – Enclosure F-1 Budget Narrative

2. Initiatives with Program Deliverables, Goals and Indicators/Outcomes

3. CalMHSA Statewide PEI Implementation Plan Themes, Priorities and Recommended Actions


5. CalMHSA Stakeholders Submission Themes by Recommended Action

6. Draft Implementation Work Plan Comments and Responses

7. Draft Implementation Work Plan Comments Verbatim

8. Reference Documents
## Appendix 1
California Mental Health Services Authority (CalMHSA)

### PEI Statewide Program Funding Request – Budget Form - Enclosure F and F-2

#### California Mental Health Services Authority (CalMHSA)

<table>
<thead>
<tr>
<th>Total All Programs</th>
<th>Funds</th>
<th>Phase 2</th>
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<tbody>
<tr>
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<td>Assigned</td>
<td>Prospective</td>
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<tr>
<td></td>
<td>Info Notice 10-06</td>
<td>Program</td>
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</table>

### Suicide Prevention (SP) Priorities

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<thead>
<tr>
<th>Program</th>
<th>Funds</th>
<th>Phase 2</th>
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<tr>
<td>SP NP - SP 1.3, 1.4, 1.11, 1.12, 1.13</td>
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<tr>
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<td>Disseminate - SP 3.8, 3.9, 3.11</td>
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<td>SP 3</td>
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<tr>
<td>Educate - SP 2.1, 2.2, 2.5</td>
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<td>Sp 4</td>
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<td></td>
</tr>
<tr>
<td>Effectiveness - SP 4.2, 4.3, 4.5, 4.6</td>
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</tr>
</tbody>
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### Stigma and Discrimination Reduction (SDR) Priorities

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<th>Funds</th>
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</tr>
</thead>
<tbody>
<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>CSDRP-SDR 1.1, 1.3, 1.5, 1.6, 1.7</td>
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<tr>
<td>SDR 2</td>
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<td>Awareness-SDR-2.1, 2.3, 2.4, 2.6, 2.9, 2.10</td>
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<td>SDR 3</td>
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<td>Increase Knowledge-SDR 4.1</td>
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<td>Regs Laws-SDR 3.1, 3.4</td>
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### Student Mental Health Initiative (SMHI) Priorities

<table>
<thead>
<tr>
<th>Program</th>
<th>Funds</th>
<th>Phase 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMHI 1</td>
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<tr>
<td>UC-SMHI Higher Ed 1, 2, 3</td>
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<tr>
<td>CSU-SMHI Higher Ed 1, 2, 3</td>
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<td>CCD-SMHI Higher Ed 1, 2, 3</td>
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<tr>
<td>Total Higher Education Allocation</td>
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<tr>
<td>SMHI 2</td>
<td></td>
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<tr>
<td>State K-12 SMHI 4</td>
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<tr>
<td>Regional K-12 SMHI 1, 2, 3, 4</td>
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<tr>
<td>Total K-12 Allocation (43.3%)</td>
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<td></td>
</tr>
<tr>
<td>Total (SMHI)</td>
<td></td>
<td></td>
</tr>
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</table>

### Total Anticipated Funds

| Total Anticipated Funds |       |         |

Prepared by: __________________________ Telephone and e-mail: __________________________
Appendix 1
California Mental Health Services Authority (CalMHSA)
PEI Statewide Program Funding Request – Budget Form - Enclosure F-1 Budget Narrative

Background

The Prevention and Early Intervention (PEI) Statewide Program Funding Request is provided and submitted in accordance with the Department of Mental Health (DMH) Information Notice No. 10-06 guidelines. These guidelines for PEI Statewide Programs provide Phase I Approval for Planning Funds and Phase II approval to expend PEI Statewide Funds on program implementation. The budget on page A1.1 represents the request for funding and approval relating to Phase II Expenditure PEI Statewide Funds on program implementation.

Total PEI Statewide Funding, as governed by DMH Information Notice No. 10-06, is $160M funded over four years ending 2012. This funding request is based on certain requirements, facts and assumptions.

1. The allocation of funding is defined with certain limits and the maximum percent by component are (DMH Information Notice No. 10-06 defines Phase I and II):
   a. 5% planning—Phase I funds ($6.8M)
   b. 15% indirect administrative costs (inclusive of 7.5% of cost of evaluation—Phase II funds ($20.4M)
   c. 80% direct service (inclusive of the required 10% operating reserve)—Phase II funds ($108M)

2. CalMHSA, at time of submission of this plan, has 29 member counties. This detail is provided on page A1.8. The funding request is based on the projected membership and total projected funding. The summary detail is as follows:
   a. Total projected funding—$136M
   b. Phase I—$6.8M
   c. Phase II—$129M

3. The JPA Agreement legally binds the JPA to the limit of funding by member and no cost overruns allowed. Thus the contingency of funding (operating reserve of 10%) is critical to the process.

4. We have utilized these maximum allocations as benchmarks, as well as defining limits for budget and procurement. It is, however, the intent of CalMHSA and its members to maximize the delivery of services. As a result this allocation shall be refined as more facts develop on an on-going basis.
5. The request for funds format has been submitted to meet the requirements of DMH Information Notice No. 10-06. The documents presented are:
   a. Enclosure F and F-2 – Budget Form (page A1.1)
   b. Enclosure F-1 – Budget Narrative (page A1.2)
   c. Member Counties spreadsheet (page A1.8)

Page A1.1 is the Funding Plan for Phase II.

**Phase I Approval for Planning**

Phase 1 approval allows for the transfer of up to four years of planning estimates to the JPA and distribution of 5% of available PEI Statewide Funds to the JPA prior to the identification of “recommended actions” from the State Strategic Plans and prior to program design. (Available funding is the amount of each annual planning estimate transferred to the JPA for prior and current fiscal years.)

The Phase I Funding requests have been requested by individual counties to be transferred to the JPA– Planning Estimate funds have been estimated on page A1.8 to be $6,810,520. Member counties posted their intent to assign funds to DMH to contract with CalMHSA for 30 days. Upon completion of 30 day posting, if no changes were made, they completed their enclosure forms and submitted them to DMH and MHSOAC and a copy to CalMHSA.

The Phase I Planning funds are not included in the budget on page A1.1.

**Phase II – Request approval to expend PEI Statewide Funds on Program Implementation**

Phase II Approval will occur when the JPA, acting on behalf of Counties, completes its design of a statewide program and submits this Implementation Work Plan update requesting approval to expend PEI Statewide Funds on program implementation. Phase II approval requires the JPA to submit program information that identifies the specific “recommended actions” to be implemented as “statewide programs” that are consistent with the State Strategic Plans: and provide associated program descriptions, budgets and evaluation strategies.

The Phase II Funding requests have been estimated based on developing membership on page A1.8 to be $129,399,881 and the amount of the PEI Statewide Funding Request on the Budget Document.

The total funding of $136,210,401 ($129,399,881 + $6,810,520) is based on surveys and communications with counties regarding their participation. The estimated funding is expected
Appendix 1  
California Mental Health Services Authority (CalMHSA)  
PEI Statewide Program Funding Request – Budget Form - Enclosure F-1 Budget Narrative

to change as actual membership develops; such changes will be presented to the MHSOAC.  
The current estimation is 85% of the total PEI Statewide Funds ($160,000,000) will participate in  
this Implementation Work Plan with the JPA. Prospective members are counties who have  
expressed the desire to join CalMHSA but are still in the process of seeking their Board of  
Supervisor approval.

State Department of Mental Health Funding Allocation Guidelines

<table>
<thead>
<tr>
<th>Phase I Planning</th>
<th>Phase II</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Program/Direct</td>
<td>Contingency Reserve$^1$</td>
</tr>
<tr>
<td>$6,810,520</td>
<td>$96,028,332</td>
<td>$12,939,988</td>
</tr>
<tr>
<td>5%</td>
<td>70.5%</td>
<td>9.5%</td>
</tr>
</tbody>
</table>

1. Contingency Reserve is calculated on 10% of Phase II funding request of $129,399,881. It  
is the intent of CalMHSA and its members to maximize the delivery of services. This  
reserve will be utilized for delivery of services.

2. The maximum allocation permitted by DMH for Indirect Administration services is 15%.  
Included in this 15% is the requirement to provide evaluation of programs. This  
allocation has been estimated and will be refined as facts develop.
### Indirect Administrative Expenses

CalMHSA will comply with the DMH Guidelines for PEI Statewide Programs in managing and controlling costs for Indirect Administrative Expenses. The Indirect Administrative Expenses will be for the following purposes and estimated by percentage:

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Percentage</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. General Management – General management of CalMHSA includes program oversight and management, administration, fiscal management and reporting, contract management membership services, information technology, Website management.</td>
<td>52%</td>
<td>$5,312,205</td>
</tr>
<tr>
<td>2. Other Contract Services – These services will include contracting for specialized services needed for specific tasks such as request for proposal writers, subject matter experts, regulatory compliance consulting and other such advisory services.</td>
<td>10%</td>
<td>$1,021,578</td>
</tr>
<tr>
<td>3. Legal Services – CalMHSA has retained general counsel to provide legal services for development of governing documents, continued correspondence with county counsels, compliance with public meeting laws and counsel to the CalMHSA Board of Directors.</td>
<td>4%</td>
<td>$408,631</td>
</tr>
<tr>
<td>4. Financial Audit – As required by state law, the Board shall cause to be made, by a qualified, independent individual or firm, an annual audit of the financial accounts and records of CalMHSA.</td>
<td>1.5%</td>
<td>$153,237</td>
</tr>
<tr>
<td>5. Insurance Expense – CalMHSA JPA is an independent governmental entity with oversight by the governing Board of Directors. CalMHSA will prudently maintain its individual policies to protect the JPA and its Board of Directors.</td>
<td>2%</td>
<td>$204,316</td>
</tr>
<tr>
<td>6. Meetings and Conferences – CalMHSA is governed by a Board of Directors and must conduct public meetings to carry out the regular business of the JPA. Conference attendance is also integral to the members maintaining and updating knowledge in mental health services.</td>
<td>5.5%</td>
<td>$561,868</td>
</tr>
<tr>
<td>7. Other Expenses – Other expenses includes items such as bank charges, travel, conferences, membership development costs and membership services associated with operating CalMHSA.</td>
<td>15%</td>
<td>$1,532,367</td>
</tr>
<tr>
<td>8. Indirect Expenses Reserve – The JPA Agreement legally binds the JPA to the limit of funding and no cost overruns allowed. Thus an indirect reserve has been established to absorb budget and cost development.</td>
<td>10%</td>
<td>$1,021,578</td>
</tr>
</tbody>
</table>

**Total** 100% $10,215,780
Appendix 1
California Mental Health Services Authority (CalMHSA)
PEI Statewide Program Funding Request – Budget Form - Enclosure F-1 Budget Narrative

<table>
<thead>
<tr>
<th>Footnote</th>
<th>Column(s)</th>
<th>Description</th>
</tr>
</thead>
</table>
| A        | (1) & (2) | **Enclosure F – Item #4 Subcontractors/Professional Services**  
The total of columns (1) and (2) of $96,023,332 has been budgeted to contract for services through request for proposal (RFP) and bid process to provide various professional services to execute the programs as described in the Implementation Work Plan. |
| B        | (3) & (6) | **Indirect Administrative Costs**  
For budgetary purposes CalMHSA has estimated 7.5% for operating expenses as described in items 1 through 3 below and 7.5% for evaluation of PEI statewide programs and projects as described in item 4 below. |

(Department of Mental Health, California Mental Health Services Authority Contract No.: 09-79119-000, Exhibit B, p. 2, April 2010)  
A maximum of fifteen percent (15%) of any and all funds that Counties have assigned to the State and or delegated to the Contractor for the purpose of funding the development and implementation of Statewide PEI programs by Contractor can be utilized for indirect administrative costs. The Contractor may request to exceed the 15% level, if the Counties that have assigned to the State and or delegated to the Contractor, have approved indirect administrative costs approved by the State that exceed 15%. Methodology for calculating the indirect administrative costs above 15% will be representative of the Counties who have assigned to the State and/or delegated to the Contractor and will be agreed upon by the Contractor and CDMH. Indirect Administrative Costs allowed for MHSA PEI Statewide programs/project include:

1) Salaries and benefits of employees who do not provide direct client services but work in accounting or budgeting or perform centralized personnel functions.
2) Operating expenses associated with staff who do not provide direct client services.

See Appendix 8 of this document
Footnote | Column(s) | Description
--- | --- | ---
3) |  | The MHSA portion of the member county OMB Circular A-87 costs to the extent they are apportioned to the JPA.
4) |  | Costs associated with evaluation of PEI Statewide programs/projects.

**C (4) Enclosure F – Disclosure Total**

The total estimated amount of PEI Statewide Program expenditures of $106,244,113 has been estimated as follows:

- Subcontract/Professional Services (Total of columns 1 and 2): $96,028,332
- Evaluations: $10,215,781

**Total: $106,244,113**

**D (5) Operating Reserve**

An operating reserve of up to ten percent (10%) of the total amount requested for direct program/project expenditures and administrative costs for each component is allowed. When determining the ten percent for the operating reserve, Counties should not include any funds requested for transfer to the Local Prudent Reserve. The operating reserve may be used by Counties at any time to provide funding for unexpected increases in costs or decreases in revenues associated with previously approved programs, or unforeseen administrative costs consistent with the requirements of the applicable component and the MHSA.

Projected contributions of $136,210,400 are based on the estimated CalMHSA JPA participation. It has been projected eighty-five percent (85%) of the California Counties and two cities will participate in the administration of statewide PEI funds through CalMHSA. The participation of members and total funds is an estimate and changes to funding are expected as actual membership develops.
## Appendix 1
California Mental Health Services Authority (CalMHSA)

### PEI Statewide Program Funding Request – Budget Form - Enclosure F-1 Budget Narrative

<table>
<thead>
<tr>
<th>Funds Assigned</th>
<th>Planning (5%) Phase I</th>
<th>Program Phase II</th>
<th>Total PEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Butte</td>
<td>$43,760</td>
<td>$831,440</td>
<td>$875,200</td>
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<tr>
<td>Colusa</td>
<td>5,000</td>
<td>95,000</td>
<td>100,000</td>
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<tr>
<td>Contra Costa</td>
<td>183,440</td>
<td>3,485,360</td>
<td>3,668,800</td>
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<tr>
<td>Fresno</td>
<td>199,700</td>
<td>3,794,300</td>
<td>3,994,000</td>
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<tr>
<td>Glenn</td>
<td>5,420</td>
<td>102,980</td>
<td>108,400</td>
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<tr>
<td>Imperial</td>
<td>37,500</td>
<td>712,500</td>
<td>750,000</td>
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<tr>
<td>Kern</td>
<td>171,180</td>
<td>3,252,420</td>
<td>3,423,600</td>
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<tr>
<td>Lake</td>
<td>11,840</td>
<td>224,960</td>
<td>236,800</td>
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<tr>
<td>Los Angeles</td>
<td>2,335,680</td>
<td>44,377,920</td>
<td>46,713,600</td>
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<tr>
<td>Marin</td>
<td>44,480</td>
<td>845,120</td>
<td>889,600</td>
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<tr>
<td>Modoc</td>
<td>5,000</td>
<td>95,000</td>
<td>100,000</td>
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<tr>
<td>Monterey</td>
<td>91,320</td>
<td>1,735,080</td>
<td>1,826,400</td>
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<tr>
<td>Orange</td>
<td>666,840</td>
<td>12,669,960</td>
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<td>Placer</td>
<td>54,820</td>
<td>1,041,580</td>
<td>1,096,400</td>
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<tr>
<td>Riverside</td>
<td>442,800</td>
<td>8,413,200</td>
<td>8,856,000</td>
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<tr>
<td>Sacramento</td>
<td>266,360</td>
<td>5,060,840</td>
<td>5,327,200</td>
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<tr>
<td>San Bernardino</td>
<td>430,760</td>
<td>8,184,440</td>
<td>8,615,200</td>
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<tr>
<td>San Diego</td>
<td>675,340</td>
<td>12,831,460</td>
<td>13,506,800</td>
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<tr>
<td>San Luis Obispo</td>
<td>51,600</td>
<td>980,400</td>
<td>1,032,000</td>
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<tr>
<td>Santa Clara</td>
<td>385,380</td>
<td>7,322,220</td>
<td>7,707,600</td>
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<tr>
<td>Santa Cruz</td>
<td>56,500</td>
<td>1,073,500</td>
<td>1,130,000</td>
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<tr>
<td>Solano</td>
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<td>1,524,180</td>
<td>1,604,400</td>
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<tr>
<td>Sonoma</td>
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<td>1,670,860</td>
<td>1,758,800</td>
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<tr>
<td>Stanislaus</td>
<td>102,040</td>
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<td>2,040,800</td>
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<td>Sutter/Yuba</td>
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<td>600,800</td>
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<tr>
<td>Trinity</td>
<td>5,000</td>
<td>95,000</td>
<td>100,000</td>
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<td>Ventura</td>
<td>166,960</td>
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<tr>
<td>Yolo</td>
<td>41,640</td>
<td>791,160</td>
<td>832,800</td>
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<td><strong>126,892,640</strong></td>
<td><strong>133,571,200</strong></td>
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### Prospective Member County

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<th>Program Phase II</th>
<th>Total PEI</th>
</tr>
</thead>
<tbody>
<tr>
<td>El Dorado</td>
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<td>551,760</td>
<td>580,800</td>
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<tr>
<td>Humboldt</td>
<td>25,140</td>
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<td>502,800</td>
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<tr>
<td>Kings</td>
<td>30,000</td>
<td>570,000</td>
<td>600,000</td>
</tr>
<tr>
<td>Mendocino</td>
<td>16,400</td>
<td>311,600</td>
<td>328,000</td>
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<tr>
<td>Napa</td>
<td>24,220</td>
<td>460,180</td>
<td>484,400</td>
</tr>
<tr>
<td>Siskiyou</td>
<td>7,160</td>
<td>136,040</td>
<td>143,200</td>
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<tr>
<td><strong>Projected Total</strong></td>
<td><strong>$6,810,520</strong></td>
<td><strong>$129,399,880</strong></td>
<td><strong>$136,210,400</strong></td>
</tr>
</tbody>
</table>
Section A. CalMHSA Strategic Plan on Suicide Prevention

Below are the CalMHSA Statewide PEI Summary of Stigma and Discrimination Reduction priorities, themes and recommended actions.

Priority 1: Create a System of Suicide Prevention

The purpose of the Statewide Suicide Prevention Network Program (SPNP) is to serve as the focal point for statewide suicide prevention activities, establish partnerships across systems and disciplines, convene population specific working groups by age and diverse populations, develop and disseminate resources, promote programs that reduce or eliminate service gaps to at-risk populations across the lifespan and in underserved racial, ethnic and cultural groups across the lifespan and implement educational, promotional and best practice strategies to prevent suicide in California. This system will consist of the following 4 actions:

Recommended Action SP 1.3:

Develop a network of public and private organizations to develop and implement strategies to prevent suicide.

Program Deliverables: An RFP will be created to implement the following deliverables:

- Create a statewide suicide prevention network
- Engage a broad spectrum of partners, including consumers, family members, youth, peer support advocacy groups, the business community, multicultural and community-based organizations, gatekeepers, etc. for all age groups and diverse populations
- Develop a comprehensive assessment of suicide prevention resources and gaps
- Provide technical assistance to local suicide prevention hotlines
- Develop culturally and age-specific specific suicide prevention trainings
- Convene state and regional forums and symposiums on Suicide Prevention

Goals:
- Reduce suicide rates in California across the age spans
Appendix 2
California Mental Health Services Authority (CalMHSA)
CalMHSA Initiatives with Program Deliverables, Goals, and Indicators/Outcomes

- Improve early identification and early intervention for at-risk suicidal behaviors across the lifespan and within diverse populations
- Increase referrals of individuals across all age groups and diverse populations with behaviors that indicate risk of suicide

Recommended Action SP 1.4

Convene and facilitate topic-specific working groups that will address specific populations and issues and develop, adapt and disseminate resources and other materials that address the topics.

Program Deliverables:
- Convene topic-specific workgroups for populations across the lifespan including diverse populations
- Identify, develop, adapt and disseminate resources that have been effective with specific age groups and diverse populations
- Organize and facilitate collaborative learning opportunities at multiple levels and across disciplines and service systems
- Identify gatekeepers models to provide education and training
- Identify develop, adapt and disseminate resources to address the dissemination of information about how and where to access services and common roadblocks

Goals:
- Develop collaborative suicide prevention models for at risk populations across the lifespan including diverse populations
- Increase and improve delivery of services through more complete integration of the systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines

Recommended Action SP 1.11:
Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines.
Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.

Program Deliverables:

- Establish and convene the Multi-Level Outreach and Engagement Program (MLOEP)
- Teach suicide risk recognition and intervention strategies and skills in personnel systems and community environments such as health clinics (e.g., primary care and prenatal care), older adult service providers, mental health centers, emergency response systems, crisis centers, alcohol and drug programs, etc.
- Facilitate collaborative learning opportunities locally and across a diversity of disciplines
- Establish and facilitate formal partnerships that foster communication and coordinated service delivery among providers from different systems

Goals:

- Reduce disparities in the availability, accessibility and quality of services for racial, ethnic and cultural groups that have been historically underserved
- Train personnel across many disciplines and systems who are in key positions to recognize and intervene when suicide risk is present

Recommended Action SP 1.13:

Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations

Program Deliverables:

- Identify or develop culturally appropriate outreach, engagement, diagnosis and intervention strategies
- Implement these strategies to specifically target historically underserved racial, ethnic and cultural groups and other at-risk populations including transition age youth including foster youth and other at-risk populations across the lifespan
Goals:

- Improve outreach, engagement, diagnosis and treatment strategies for cultural communities
- Increase the availability of innovative outreach and intervention strategies for underserved racial and ethnic groups and other at-risk populations

Recommended Action SP 1.12:

Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace and the criminal and juvenile justice systems.

Program Deliverables:

- Increase the availability of mental health and suicide prevention services in K-12 schools
- Increase the availability of mental health and suicide prevention services on college campuses
- Develop peer-to-peer services for suicide prevention on college campuses
- Increase the availability of community-based programs that target older adult mental health, and that complement outreach, engagement, and education opportunities that currently exist within the local community structure, and are services that older adults commonly use
- Increase the capacity of school programs to build resiliency among students by adopting curricula that teach problem-solving skills, coping and support-seeking strategies
- Develop strategies to reach out to those who are at high risk of suicide
- Integrate suicide prevention into work settings for adults who may be at risk but not likely to seek out mental health services
- Develop strategies to address suicide prevention among veterans
Goals:

- Increase the number of school and campus-based mental health and suicide prevention programs
- Enhance the capacity of schools to build resiliency among students
- Enhance the capacity of older adult service providers, programs and gatekeepers to identify the signs and symptoms of depression and suicide risk, and to provide appropriate suicide prevention interventions and referral services
- Increase the number of organizations that integrate suicide prevention into workplace settings
- Increase the availability of mental health and suicide prevention services and curricula in schools K-12 and on college campuses
- Increase the number of local partnerships between and within the criminal justice system and the local community

Recommended Action SP 1.5 and SP 1.6:
Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level. Enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

Program Deliverables:

- Create a statewide consortium of suicide prevention hotlines
- Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as web sites
- Hotlines should target specific populations such as youth, older adults, veterans, transition age youth including foster youth, etc.
- Build capacity for local suicide prevention hotlines to become accredited
• Identify and implement strategies to expand resources and services for accredited suicide prevention hotlines, such as training centers and aftercare services

• Establish, build and maintain a statewide consortium of suicide prevention hotlines to focus on policy development and law enactment that will require accreditation as a condition of public funding for suicide prevention hotlines

• All initiatives should be culturally and linguistically competent, respectful and inclusive of California’s diverse population across all age groups including seniors

Goals:

• Increased number and capacity of accredited suicide prevention hotlines based in California

• Expanded reach of accredited suicide prevention hotlines through various communication and technology means

In the upcoming process of developing RFPs, specific outcomes related to the goals and deliverables will be articulated. Following are examples of potential outcomes and indicators that may be specified for Recommended Actions SP 1.3, 1.4, 1.11, 1.12, 1.13, 1.5 and SP 1.6

For individual/family prevention activities:

• Increased knowledge, of social, emotional and behavioral issues and improved attitudes, beliefs and behaviors

• Increased knowledge of risk and resilience/protective factors

For individual/family early intervention activities:

• Enhanced resilience and protective factors

• Increased help-seeking and referrals from consumers and their family members

• Improved mental health status

• Improved school performance

• Increased social support
• Reduced incidence of suicide

Changes in non mental health partner organizations/systems:

• Enhanced capacity of organizations to provide suicide prevention and early intervention programs
• Increase in number of accredited suicide prevention programs
• Increase in number of organizations providing suicide prevention and early intervention activities
• Increase in number of organizations integrating suicide prevention and early intervention activities into current efforts

Priority 2: Educate Communities to Take Action to Prevent Suicide

The purpose of the Social Marketing Suicide Prevention Campaign Program (SMSPCP) is to raise awareness that suicide is preventable and support help-seeking behaviors by improving media presentation of mental illness and suicide through electronic and print media messages and through media education. This campaign consists of the following 3 actions:

Recommended Action: SP 3.2

Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

Program Deliverables: An RFP will be created to implement the following deliverables:

• Identify and implement population-specific strategies that promote suicide prevention across the lifespan and within diverse populations
• Develop and implement an age-appropriate, multi-language education campaign targeting at risk populations across all ages and diverse populations
• Develop statewide suicide prevention education campaigns that coordinate suicide prevention and anti-stigma efforts and complement other local and national suicide prevention and anti-stigma campaigns
Goals:

- Increase public awareness through suicide prevention/anti-stigma education and sensitivity through collaborative social marketing and education campaign efforts

- Increase the likelihood for individuals across all populations to seek help for a mental health need by reducing the associated stigma through population-specific strategies that promote suicide prevention

**Recommended Action SP 3.3**

Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness and mental health services that support suicide prevention efforts.

**Program Deliverables:** An RFP will be created to implement the following deliverables:

- Create ongoing relationships with local media contacts and local entities

- Provide media contacts with education and information about balanced messages related to the coverage of suicide

Goal:

- Improve the way in which the news media and the entertainment industry portray suicide incidents and people at risk for suicide

- Increase collaboration with media contacts to support the media’s dissemination of accurate information and balanced messages

**Recommended Action SP 3.7**

Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.

**Program Deliverables:** An RFP will be created to implement the following deliverables:

- Establish ongoing relationships with local media contacts

- Include local media contacts in efforts to develop suicide prevention education campaigns
Appendix 2
California Mental Health Services Authority (CalMHSA)
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- Disseminate suicide prevention-related information and resources to local media contacts

**Goals:**

- Improve the way in which the news media and the entertainment industry portray suicide incidents through engagement and education of media contacts.
- Mobilize the media to educate the public about suicide prevention

Following are examples of Potential Outcomes/Indicators for evaluation of SP 3.2, 3.3 and SP 3.7:

- Increase the number of coordinated suicide prevention media campaigns
- Increase the availability of collaborative learning opportunities for local media contacts
- Increase in number of articles and amount of air time that media devotes to suicide prevention
- Improved adherence to guidelines for reporting of suicide risk

**Priority 2: Educate Communities to Take Action to Prevent Suicide**

The purpose of the Statewide Suicide Prevention Information and Dissemination Campaign Education Program (SPIDCEP) is to provide family, peer and consumer education through evidence-based gatekeeper training models and to incorporate and build capacity for peer support and peer support service models. The development of program curriculum shall target professionals across systems and disciplines and may also connect with the higher education initiative. This program consists of the following three actions:

**Recommended Action SP 3.8**

Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and community members to recognize, appropriately respond to and refer people demonstrating acute warning signs.

**Program Deliverables:** An RFP will be created to implement the following deliverables:

- Provide family, peer, transition age youth including foster youth and consumer education through evidence-based population-specific gatekeeper training models that
identify and implement population-specific (by age, race, culture, ethnicity and gender) strategies and promote gatekeeper models as an effective strategy of reaching high risk individuals

- Engage the expertise and experience of existing survivor, transition age youth including foster youth, peer and family support groups to build a coordinated network and develop materials to support the expansion of these groups around the state

- Identify and implement population-specific strategies that promote suicide prevention

Goal:
- Increase suicide prevention and risks and warning signs education that is tailored for family, peer and consumer populations

**Recommended Action SP 3.9**

Promote and provide suicide prevention education for community gatekeepers.

**Program Deliverables:** An RFP will be created to implement the following deliverables:

- Conduct regional train-the-trainer gatekeeper training that includes age, race, culture, ethnicity, and gender-specific strategies

- Support and promote gatekeeper models as an effective strategy of reaching high risk individuals

- Identify and implement population-specific strategies that promote suicide prevention across the lifespan

- Conduct regional train-the-trainer gatekeeper training

- Establish a partnership with aging services providers in California to develop a statewide training model that is available online

**Goals:**
- Promote suicide prevention and risks awareness and greater understanding locally and regionally through train-the-trainer gatekeeper models
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- Increase providers’ capacity to recognize suicide risk among the elderly and to provide access to information about effective interventions

Recommended Action SP 3.11

Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

Program Deliverables: An RFP will be created to implement the following deliverables:

- Incorporate and build capacity for peer support and peer-operated services models as essential tools of suicide prevention and follow-up services

- Develop a “how to” manual for sustaining survivor support groups locally, including information about funding, training, and establishing a 501c3 status and sustainability

Goal:

- Incorporate and build capacity for peer support and peer-operated service models

Following are examples of potential outcomes and indicators that may be specified for Recommended Actions SP 3.8, SP 3.9 and SP 3.11:

- Increase in number of informed responses to individuals demonstrating suicide warning signs

- Increased number of trained gatekeepers and enhanced capacity for peer support and peer-operated service models

- Increased number of high risk individuals with access to suicide prevention education and peers who have been trained through Gatekeeper Suicide Prevention Models

- Increase the number of local survivor support groups

- Increase the organizational sustainability of local survivor support groups

Priority 3: Implement Training and Workforce Enhancements to Prevent Suicide

The purpose of the Suicide Prevention Training and Workforce Enhancement Program (SPTWEP) is to develop and implement service and training guidelines to promote effective and
consistent suicide prevention, early identification, referral, intervention and follow-up care across all service provider systems and organizations. The development of program curriculum shall target professionals across systems and disciplines and might also connect to the higher education initiative. This program consists of the following three actions:

**Recommended Action SP 2.1**

Convene expert workgroups to recommend, develop, disseminate, broadly promote and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.

**Program Deliverables:** An RFP will be created to implement the following deliverables:

- Organize and facilitate expert workgroups to develop or identify training guidelines and curricula for distribution to service providers, including peer-to-peer support providers
- Increase the availability of training guidelines that promote effective and consistent suicide prevention, early identification, referral, intervention and follow-up care across all service providers
- Engage mental health professional groups on how to expand the incentives and accessibility of suicide, prevention and early intervention training

**Goal:**

- Improve the service approaches and training of suicide prevention services and peer-to-peer support providers to reflect best practices

**Recommended Action SP 2.2**

Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing and graduate programs.

**Program Deliverables**

- Assist professionals across systems and disciplines in their curriculum development efforts and ensure that curriculum addresses cultural and age-specific needs and targets professionals across systems and disciplines
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- Assist professionals across systems and disciplines in their curriculum development efforts. At a minimum, occupations selected for guidelines and curricula development and training should include:
  
  - Primary care providers, including physicians and mid-level practitioners
  - First responders, including police officers and sheriffs, emergency department staff and emergency medical technicians
  - Community clinics and health centers
  - Mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
  - Social workers and other staff in older adult programs, in-home support services, adult and child protective services and foster care
  - Adult and juvenile system correction officers and probation and parole officers
  - Administrators and faculty in elementary, middle and high schools and colleges and universities

Goals:

- Expand opportunities for suicide prevention training
- Increase number of trained professionals across disciplines and across professions and systems

Recommended Action SP 2.5:

Increase the priority of suicide prevention training through outreach and by disseminating, tailoring and enhancing state training guidelines as necessary to meet local needs.

Program Deliverables:

- Develop an infrastructure to identify and respond to suicide risk
- Develop and implement service and training guidelines
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- Assess current criteria and standards for service and training that address suicide prevention, early intervention, treatment and follow-up care
- Develop statewide standards and guidelines for specific populations and settings

Goal:
- Enhance statewide training guidelines for specific populations and raise the priority of suicide training towards meeting local needs

Following are examples of potential outcomes and indicators that may be specified for

Recommended Actions: SP 2.1, SP 2.2 and SP 2.5:

- Informed community and appropriate guidelines to support statewide training related to recognition of culturally competent and age and appropriate response to individuals demonstrating suicide warning signs
- Increased number of trained professionals, gatekeepers, etc.
- Developed statewide infrastructure for identifying and responding to suicide risk

Priority 4: Improve Suicide Prevention Program Effectiveness and System Accountability

The purpose of the Suicide Prevention Evaluation and Accountability Program (SPEAP) is to improve data collection, surveillance and program evaluation and launch a research agenda to design responsive policies and effective programs to reduce the impact of suicide in diverse populations. This program consists of the following four actions:

Recommended Action: SP 4.2
Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.

Recommended Action: SP 4.3
Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods and provide training and technical assistance on program evaluation to the counties and local partners.
Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.

**Recommended Action: SP 4.5**

Increase local capacity for data collection, reporting, surveillance and dissemination to inform prevention and early intervention program development and training.

**Recommended Action: SP 4.6**

Build local capacity to evaluate suicide prevention programs, including community-based participatory research methods and use evaluation results to make program improvements.

These actions shall be included in a statewide evaluation RFP with expectations of data collection for each program.

**Program Deliverables:**

- Develop, test and adapt evidence-based practices
- Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods
- Provide training and technical assistance on program evaluation to counties and local partners
- Develop methodologies to promote the evaluation of promising community-based models to build their evidence base
- Increase local capacity for data collection, reporting, surveillance and dissemination
- Build local capacity to evaluate suicide prevention programs, including community-based participatory research methods
- Improve data collection, surveillance and reporting to better understand specific populations, suicide trends and the impact of protective factors and risk factors in diverse populations
- Provide technical assistance for the development of evaluation activities that support the scopes of work of CalMHSA providers and organizations
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Goals:

- Improve data collection, surveillance and program evaluation
- Successful implementation of a research agenda to design responsive policies and effective programs that reduce the impact of suicide in diverse populations

Following are examples of potential outcomes and indicators that may be specified for SP 4.2, 4.3, 4.5, and SP 4.6

- Increase in the number of suicide prevention programs that are conducting local formal evaluations
- Increase the number of suicide prevention programs that are participating in statewide evaluation procedures
- Increase in the quality of data regarding suicide trends, protective and risk factors, and population variables
- Increase in the amount of evaluation data pertaining to suicide prevention programs

Section B. CalMHSA Implementation Work Plan on Stigma and Discrimination Reduction

Below are the CalMHSA Statewide PEI Summary of Stigma and Discrimination Reduction priorities, themes and recommended actions.

A set of “Core Principles” were at the forefront of the original “California Strategic Plan on Reducing Mental Health Stigma and Discrimination”. Several of these should be noted and incorporated when addressing all the priorities and recommended actions:

- Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations
- Employ a life-span approach to effectively meet the needs of different age groups
- Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experience mental health challenges comes from voluntary programs that offer choice and options
Priority One: Create a Supportive Environment for Consumers, Family and Others that Crosses a Lifespan Focus

The purpose of the mental well-being initiative is to create a supportive environment for all consumers and those at risk for mental health challenges, family members and the community at large, establishing social norms that recognize mental health as integral to everyone’s well-being. This program consists of the following five actions:

**Recommended Action: SDR 1.1**

Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery.

**Recommended Action: SDR 1.3**

Create opportunities and forums for strengthening relationships between consumers, family members and the larger community

**Recommended Action: SDR 1.5**

Recognize peer run and peer led programs as an important means for reducing stigma

**Recommended Action: SDR 1.6**

Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases

**Recommended Action: SDR 1.7**

Provide increased support for those closely involved with the lives of individuals facing mental health challenges

Program Deliverables:

- Form a statewide collaborative of local coalitions of diverse representatives, including those with mental health challenges in their families, individuals knowledgeable about serving underserved cultural communities in the area, and representatives across the age span.
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- Launch a community action plan to inform the general public about mental health and to reduce stigma and discrimination
- Develop electronic and print materials for the general public that are culturally and age appropriate including materials in at least three threshold languages (other than English)
- Assess existing print and electronic media about mental health challenges and emotional disturbances
- Improve consumer-driven information to reflect and reinforce recovery, resilience and wellness
- Promote the development of informative and accurate internet resources
- Rely on mental health consumers and family members, including those from underserved cultural communities to raise awareness of the importance of mental health across the lifespan
- Confront stigmatizing messages and identify how everyday language reinforces stigma and discrimination
- Develop age appropriate electronic and print media for the general public that are culturally and age appropriate to counter stigma and discrimination including materials in at least threshold languages (other than English)

Programs that provide peer-run and peer-led programs are an important means for reducing stigma. Program interventions will utilize a lifespan approach and address the following:

- Assess, develop and disseminate information on peer-run and peer-led programs and social support models
- Work with local and statewide organizations to promote coordinated message topics and the timelines for delivery
- Develop statewide support for local speaker bureaus, presentations and forums from across the lifespan
Promote education and skill-based training for consumer and family empowerment

Utilize technology to support groups or individuals who are geographically or emotionally isolated

Enhance the skills of peers to be more effective trainers of mental health staff

Create training and advancement opportunities for individuals working to reduce stigma and discrimination

Develop and coordinate a peer-to-peer network of support for veterans with the California National Guard and veteran organizations

Programs may address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination, based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases, with efforts to:

Disseminate successful models for reducing stigma and discrimination that have been identified by cultural communities

Work with consumers from the target population to ensure age and generational relevance

Educate substance abuse providers and mental health providers

Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases

Applicants may address increased support for those closely involved with the lives of individuals facing mental health challenges, with efforts to:

Apply innovative information technologies that will allow parents, foster parents and caregivers to obtain accurate information, guidance and referrals to seek needed services
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- Identify non-traditional community locations to distribute information on available mental health resources for populations across the lifespan and in underserved ethnic, racial and cultural populations

Goals:
- Create a supportive environment for all consumers and those at risk for mental health challenges and for family and community members
- Establish social norms that recognize mental health as integral to everyone’s well-being
- Create anti-stigma programs for widespread understanding and recognition within the general public and across all systems

Following are examples of potential outcomes and indicators that may be specified for SDR 1.1, 1.3, 1.5, 1.6 and SDR 1.7:
- Supportive consumer and family environments
- Change in social norms reflecting recognition of mental health as integral to everyone’s well-being.
- Increased availability of anti-stigma programs to create widespread understanding of mental health challenges and suicide risk and prevention
- Measurable increase in understanding of mental health challenges and suicide risk and prevention strategies on the part of trained personnel, community gatekeepers and peer-to-peer support providers
- Positive change in knowledge, attitudes, and behaviors that is noted and assessed, statewide

Priority Two: Promote Awareness, Accountability and Change
The purpose of this program is to promote awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges. This program will consist of the following six actions:
Recommended Action SDR 2.1

Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices and policies.

Recommended Action SDR 2.3

Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.

Recommended Action SDR 2.4

Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.

Recommended Action SDR 2.6

Educate employers on the importance of mental health wellness for all employees.

Recommended Action SDR 2.9

Engage and educate the commercial, ethnic, public/community and interactive media, as well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate anti-stigma information to the public on mental health issues and community resources.

Recommended Action SDR 2.10

Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance.

Program Deliverables:

- Support ethnic diversity, cultural competency and age appropriate training
- Train mental health and system partner staff on stigma and discrimination reduction
- Support training for mental health and system partner staff that serve populations across the lifespan and underserved ethnic, racial and cultural communities
To create a more holistic and integrated approach to physical health and mental wellness, applicants might:

- Sponsor local and statewide programs to support medical practitioners
- Screen for and address both mental and medical needs of individuals entering a mental health facility
- Train providers on the value of spirituality and cultural competence in the wellness and recovery process
- Educate employers on the importance of mental health wellness for all employees
- Engage and educate the commercial, ethnic, public/community and interactive media, as well as the entertainment industry about the importance of mental health wellness
- Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance

Goals:

- Promote greater awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations and with consumers and stakeholder involvement
- Engender holistic and integrated approaches to physical and mental wellness

Following are examples of potential outcomes and indicators that may be specified for SDR 2.1, 2.3, 2.4, 2.6, 2.9 and SDR 2.10:

- Improvement in knowledge, attitudes, skills and behavior of employers and others receiving training
- Increase in awareness of the importance of mental health within organizations
- Specific changes in policies and procedures related to the program goals within organizations receiving services
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California Mental Health Services Authority (CalMHSA)
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- Increased respect and awareness of the rights of people identified with mental health challenges

Priority 3: Increase Knowledge of Effective and Promising Programs that Reduce Stigma

The purpose of this program is to increase knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches. This program consists of the following action:

Recommended Action: SDR 4.1

The purpose of this program is to increase knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

Program Deliverables:

- Develop incentives to build partnerships between academic research and community-based research
- Provide assistance to counties in developing anti-stigma and anti-discrimination programs
- Utilize multi-disciplinary research techniques to guide research on the diversity of forms of mental health stigma and discrimination
- Identify research techniques for the evaluation of anti-stigma programs for local use

Goals:

- Increase in partnerships between academic and community-based research
- Increase in use of effective and promising programs, all leading to reduced stigma and discrimination
- Reduced stigma and discrimination as a result of collaboration between research institutions and counties

Following are examples of potential outcomes and indicators that may be specified for SDR 4.1:
Greater system and organizational awareness, collaborations, use of community-led approaches and partnerships between academic and community-based participatory research

- Increased use of community-led approaches
- Increased use of identified effective and promising practices that lead to reduced stigma and discrimination

**Priority 4: Uphold and advance federal and state laws to support the elimination of discriminatory practices**

The purpose of this program is to uphold and advance federal and state laws to identify and eliminate discriminatory policies and practices. This program will consist of the following two actions:

**Recommended Action SDR 3.1**

Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.

**Recommended Action SDR 3.4**

Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.

**Program Deliverables:**

- Review federal and state regulations that support mental health services in non-traditional settings to reduce stigma
- Assess if existing laws, policies or procedures are complied with, or enforced
- Identify situations and circumstances where improvement is needed in enforcement of anti-discrimination laws and regulations
- Increase awareness and understanding of existing anti-discrimination laws and policies
- Widely disseminate age-specific user-friendly fact sheets with contact information for education and training purposes
Goals:

- Development of policies and mechanisms within the criminal and juvenile justice system to more appropriately meet the needs of individuals with mental health challenges
- Reduction in discrimination and stigmatization within the criminal justice system

Following are examples of potential outcomes and indicators that may be specified for programs related to SDR 3.1 and SDR 3.4:

- Improved policies and mechanisms that support and appropriately address mental health challenges and help eliminate discriminatory practices within the criminal and juvenile justice system
- Improved juvenile and criminal justice system capability to meet the needs of individuals with mental health challenges
- Reduction in instances of stigmatization and discrimination within the juvenile and criminal justice system

Section C. CalMHSA Implementation Work Plan on the Student Mental Health Initiative

The purpose of the Student Mental Health Initiative (SMHI) is to provide an opportunity for California schools and higher education institutions to strengthen mental health programs. Key elements of SMHI include: campus-based mental health programs, mental health promotion programs, early intervention, peer-to-peer support activities, suicide prevention programs, referrals and linkages.

The format below is tailored for SMHI and is somewhat different than the formats in the previous sections for Suicide Prevention (SP) and Stigma and Discrimination Reduction (SDR). It is planned for all recommended actions to be implemented. Another distinguishing factor for the SMHI is the separation of initiatives for Higher Education (with subdivisions for UC, CSU and CCC) and K-12; with recommended allocations of approximately 60/40 percent ratio.

Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention
The purpose of the University and College Student Mental Health Program (UCSMHP) is to implement training, peer-to-peer support and suicide prevention within each of the three higher education systems: University of California (UC), California State University (CSU) and California Community Colleges (CCC). The UCSMHP will be established in each of the higher education systems.

The UCSMHP will emphasize age specific, culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention (PEI) plans and/or community services and supports plans and collaboration with mental health and substance abuse prevention partners.

Program Deliverables:

- Mental health and wellness training activities for students, faculty, staff and administrators

- Individuals who are bilingual and ethnically diverse, and who identify as LGBTI should be trained. The training should have a component on cultural sensitivity so that trainees will be better able to identify and assess for stressors that can impact the mental health of students in higher education

- Educate students on their rights to services, and address myths regarding losing scholarships, confidentiality, parental rights, and being expelled

- Peer-to-peer support activities that focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies and reduction of the stigma associated with mental illness. Peers with experience accessing mental health services would be beneficial. Peers who are ethnically or culturally diverse or who identify as LGBTI may provide effective support to students who are diverse

- Suicide prevention activities that target unserved and underserved (e.g.: Asian American students, LGBTQ students, international students, first generation college students, students with disabilities, and other unserved populations)

- Suicide prevention programs that utilize the resources and best-practices of the MHSA suicide prevention efforts and bring suicide prevention resources directly onto campuses
Goals: By enhancing factors that increase a student’s ability to succeed in school and by reducing factors that impede or create barriers to student academic success, the UCSMHP strategies aim to: Improve academic achievement, increase student retention, increase student graduation and increase supportive services available to students. Long-term cost savings are attributed to reduced economic/social burden (as mental health problems are addressed early) and reduced cost of higher education dropouts.

Theme and Priority: Kindergarten – Twelfth Grade Training, Peer Support and Suicide Prevention

The purpose of the Kindergarten to Twelfth Grade Student Mental Health Program (K-12 SMHP) is to provide school-based programs, systems and policy developments, education and training and technical assistance in schools districts. Initial implementation of the K-12 SMHIP may include establishing demonstration programs through the eleven County Superintendent of Schools superintendent regions whose aim is to work collaboratively with school districts to ensure that every student benefits from a quality educational experience, regardless of their circumstances.

Program Deliverables:

- A statewide advisory body that convenes and staffs a “Student Mental Health Policy Workgroup” that includes key mental health provider agencies who serve individuals who are ethnically and culturally diverse individuals, or who identify as LGBTI, and oversees statewide coordination of K-12 programs across the Superintendent Regions and advises on development of the SMHI for K-12

- Training should include how discrimination or bias toward ethnically and culturally diverse students or students who identify as LGBTI can result in injurious and harmful consequences

- A Regional K-12 responsible for school-based programs, technical assistance, education and training across regional programs

- School-Based Grant Programs, including K-12 SMHIP, that provide a continuum of prevention and early intervention services including:
  - Linkages to services provided on campus or otherwise provided through school health centers, county departments of mental health, foster care systems serving
transitional age youth, special education programs and community-based organizations. Linkages should include community-based organizations who serve ethnically and culturally diverse and LGBTI individuals

- Linkages to services that are inclusive of county/local C School Attendance Review Boards (SARBs) pursuant to Education Code Section 48321 as mental health representatives add expertise and resources for high-risk students

- Use of appropriate youth peer-to-peer strategies such as school-based programs that include combinations of campus-based programs and the use of online tools

- Technical assistance to bring together expertise with various organizations and to support program development and implementation

**Goals:** Increased effectiveness of Kindergarten – 12th Grade Student Mental Health Initiative (K-12 SMHI) programs. K-12 SMHI strategies aim to: Improve academic achievement, reduce discipline referrals, increase student attendance and retention, increase student graduation and improve the general school climate. Long-term cost savings are attributed to reduced economic/social burden as mental health problems are addressed early and reduced cost of school dropout.

**Evaluation of SMHI:** The evaluation of the UCSMHP and K-12 SMHI will cover performance as well as outcome measures. Outcome reviews may evaluate increased school success, decreased school drop-out rates, reduced school suspensions and expulsions for behavior problems, increased identification of early signs of mental illness, reduced stigma and discrimination related to mental health, increased access to services, increased linkages with community resources, increase in parent or student awareness of available support resources and students or families own satisfaction with care.
### Section A. CalMHSA Strategic Plan on Suicide Prevention

#### Theme and Priority One: Create a System of Suicide Prevention

**Recommended Actions:**

<table>
<thead>
<tr>
<th>SP 1.3</th>
<th>Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide.</th>
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</thead>
<tbody>
<tr>
<td>SP 1.4</td>
<td>Convene and facilitate topic-specific working groups that will address specific populations and issues and develop, adapt and disseminate resources and other materials that address the topic.</td>
</tr>
<tr>
<td>SP 1.5</td>
<td>Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.</td>
</tr>
<tr>
<td>SP 1.6</td>
<td>Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as web sites.</td>
</tr>
<tr>
<td>SP 1.11</td>
<td>Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers.</td>
</tr>
<tr>
<td>SP 1.12</td>
<td>Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace and the criminal and juvenile justice systems.</td>
</tr>
<tr>
<td>SP 1.13</td>
<td>Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.</td>
</tr>
</tbody>
</table>
**Theme and Priority Two: Educate Communities to Take Action to Prevent Suicide**

**Recommended Actions:**

<table>
<thead>
<tr>
<th>SP 3.2</th>
<th>Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.</th>
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<tbody>
<tr>
<td>SP 3.3</td>
<td>Engage the news media and the entertainment industry to educate them on standards and guidelines to promote balanced and informed portrayals of suicide, mental illness and mental health services that support suicide prevention efforts.</td>
</tr>
<tr>
<td>SP 3.7</td>
<td>Create opportunities to promote greater understanding of the risks and protective factors related to suicide and how to get help by engaging and educating local media about their role in promoting suicide prevention and adhering to suicide reporting guidelines.</td>
</tr>
<tr>
<td>SP 3.8</td>
<td>Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and community helpers to recognize, appropriately respond to and refer people demonstrating acute warning signs.</td>
</tr>
<tr>
<td>SP 3.9</td>
<td>Promote and provide suicide prevention education for community gatekeepers.</td>
</tr>
<tr>
<td>SP 3.11</td>
<td>Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.</td>
</tr>
</tbody>
</table>
### Theme and Priority Three: Implement Training and Workforce Enhancements to Prevent Suicide

**Recommended Actions:**

| SP 2.1 | Convene expert workgroups to recommend, develop, disseminate, broadly promote and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California. |
| SP 2.2 | Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing and graduate programs. |
| SP 2.5 | Increase the priority of suicide prevention training through outreach and by disseminating, tailoring and enhancing state training guidelines as necessary to meet local needs. |

### Theme and Priority Four: Improve Suicide Prevention Program Effectiveness and System Accountability

**Recommended Actions:**

| SP 4.2 | Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups. |
| SP 4.3 | Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods and provide training and technical assistance on program evaluation to the counties and local partners.  
   
   Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities. |
Appendix 3
California Mental Health Services Authority (CalMHSA)
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| SP 4.5 | Increase local capacity for data collection, reporting, surveillance and dissemination to inform prevention and early intervention program development and training. |
| SP 4.6 | Build local capacity to evaluate suicide prevention programs, including community-based participatory research methods and use the results to make program improvements. |

Section B. Stigma and Discrimination Reduction: Statewide Program Activities

Theme and Priority One: Create a Supportive Environment for Consumers, Family and Others that Crosses a Lifespan Focus

Recommended Actions:

| SDR 1.1 | Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery. |
| SDR 1.3 | Create opportunities and forums for strengthening relationships between consumers, family members and the larger community. |
| SDR 1.5 | Recognize peer run and peer led programs as an important means for reducing stigma. |
| SDR 1.6 | Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases. |
| SDR 1.7 | Provide increased support for those closely involved with the lives of individuals facing mental health challenges. |
Theme and Priority Two: Promoting awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

Recommended Actions:

<table>
<thead>
<tr>
<th>SDR 2.1</th>
<th>Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices and policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SDR 2.3</td>
<td>Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.</td>
</tr>
<tr>
<td>SDR 2.4</td>
<td>Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.</td>
</tr>
<tr>
<td>SDR 2.6</td>
<td>Educate employers on the importance of mental health wellness for all employees.</td>
</tr>
<tr>
<td>SDR 2.9</td>
<td>Engage and educate the commercial, ethnic, public/community and interactive media, as well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate anti-stigma information to the public on mental health issues and community resources.</td>
</tr>
<tr>
<td>SDR 2.10</td>
<td>Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance.</td>
</tr>
</tbody>
</table>
Theme and Priority Three: Increasing knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

Recommended Actions:

**SDR 4.1**
Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination to build effective and promising anti-discrimination programs.

Theme and Priority Four: Upholding and advancing federal and state laws to identify and eliminate discriminatory policies and practices.

Recommended Actions:

**SDR 3.1**
Increase awareness and understanding of existing laws and regulations that protect individuals living with mental health challenges and their family members against discrimination.

**SDR 3.4**
Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.

Section C. California Strategic Plan on Student Mental Health Initiative

Statewide Program Activities for Higher Education

Theme and Priority: Design and administer programs that will focus on three key strategic directions: training, peer support activities and suicide prevention. Any college, district, multi-campus collaborative, or system within each of the three California public higher education systems would be eligible. Successful programs will be based on demonstrated need and will emphasize culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention plans and/or Community Services and
Supports plans and collaboration with mental health and substance abuse prevention partners. It is the intent of the MHSOAC that programs will be established in each of the three public higher education systems.

**Recommended Actions:**

| SMH 1 | **Training:** The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness and to promote a campus environment that enhances student success providing hope, supporting resiliency and creating a healthy learning community. |
| SMH 2 | **Peer-to-Peer Support:** These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves. |
| SMH 3 | **Suicide Prevention:** These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible. |

**KINDERGARTEN THROUGH TWELTH GRADE:** Statewide Program Activities

**Theme and Priority:** Design and administer programs that address the systemic challenges in providing a comprehensive approach to addressing student mental health. Successful programs will take the variety of discrete school-based
mental health interventions and programs that have been proven effective and combine them into a comprehensive student mental health program.

**Recommended Actions:**

<table>
<thead>
<tr>
<th>SMH 1</th>
<th>School-Based Programs: Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including:</th>
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<tbody>
<tr>
<td></td>
<td>- Efforts that foster supportive school climates, including bullying prevention, suicide prevention, stigma reduction and cultural awareness</td>
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<td>- Mental health educational programs for students that include a focus on stigma reduction, incorporate age-appropriate suicide prevention training for the general student population and are in alignment with state Health Education Standards</td>
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<td>- Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps</td>
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<td></td>
<td>- Collaboration with community-based providers that enhance student success, for example, health services, tutoring, afterschool programs and mentoring</td>
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<td></td>
<td>- Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers</td>
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<td>- Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs and community-based organizations</td>
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<td>- Outreach and education for families that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services</td>
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</table>
Appendix 3  
California Mental Health Services Authority (CalMHSA)  
Recommended Actions

<table>
<thead>
<tr>
<th>SMH 2</th>
<th>Systems and Policy Developments: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:</th>
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<tbody>
<tr>
<td></td>
<td>• Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.</td>
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<tr>
<td></td>
<td>• Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.</td>
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<td></td>
<td>• Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.</td>
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<td></td>
<td>• Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.</td>
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</tbody>
</table>

- Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, example suicide risk among African-American and Caucasian males, Asian American females, Hispanic males and females, LGBTQ youth and Native American youth
- Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral and non-stigmatizing responses
- Use of appropriate youth peer-to-peer strategies
- Procedures for ongoing assessment of student mental health and continuous improvement of school-based programs.

- Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech language therapists and audiologists, resource specialists and school nurses where available, in the planning and executing of systems and policy changes.

- Meet current state curriculum mandates for health and wellness.

<table>
<thead>
<tr>
<th>SMH 3</th>
<th>Education and Training: School/district personnel should receive education and training to support the successful implementation of specific school-based programs and the systems and policy changes needed to sustain these programs.</th>
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<tbody>
<tr>
<td>SMH 4</td>
<td>Technical Assistance: In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned and access to on-site consultation to increase the effectiveness of SMHI-funded programs.</td>
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### Appendix 4
California Mental Health Services Authority (CalMHSA)

**CalMHSA 52-Day Stakeholder Input Process: Submissions by Organization, Individual and Locality**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategic Plans Submitted On</th>
<th>Priorities and/or Comments Submitted</th>
<th>Geographic Scope</th>
<th>Entity</th>
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<td>Catherine A. Huerta</td>
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<tr>
<td><strong>Cathy Spensley, MSW</strong>&lt;br&gt;Family Service Agency of San Francisco</td>
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<td><strong>Christa Thompson</strong>&lt;br&gt;Calaveras County Behavioral Health Services</td>
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<td><strong>Christin Hemann</strong>&lt;br&gt;Aging Services of California</td>
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<td><strong>David Kopperud</strong>&lt;br&gt;California Association of Supervisors of Child Welfare and Attendance</td>
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<td><strong>David N. Thorne</strong></td>
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<td><strong>Delphine Brody</strong>&lt;br&gt;California Network of Mental Health Clients</td>
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<td><strong>Diane A. Suffridge, PhD</strong>&lt;br&gt;Family Service Agency of Marin</td>
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<td><strong>Donna Peterson</strong>&lt;br&gt;San Diego Coalition for Mental Health</td>
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<td><strong>Erick</strong></td>
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<td>Leslie Lessenger, PhD, Napa-Solano Psychological Association</td>
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<td>Priorities, comments</td>
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<tr>
<td>Lin Benjamin, MSW, MHA, California Department of Aging</td>
<td>✅</td>
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<tr>
<td>Lisa Nerenberg, California Elder Justice Workgroup</td>
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<tr>
<td>Luther Hert, Monterey County Mental Health Commission – Member</td>
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<td>Margaret Hallett, Executive Director, Family Service Agency of Marin</td>
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<tr>
<td>Michelle Callejas, MFT, Sacramento County Department of Behavioral Health Services</td>
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## Appendix 4
California Mental Health Services Authority (CalMHSA)

### CalMHSA 52-Day Stakeholder Input Process: Submissions by Organization, Individual and Locality

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategic Plans Submitted On</th>
<th>Geographic Scope</th>
<th>Entity</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stigma &amp; Discrimination Reduction</strong></td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>Monica Nepomuceno, California Department of Education</td>
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<td>State</td>
<td>K-12</td>
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<tr>
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<tr>
<td>Nancy A. Salamy, MFT, Executive Director Crisis Support Services of Alameda County</td>
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<tr>
<td><strong>Priorities and/or Comments Submitted</strong></td>
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<td></td>
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<tr>
<td>Patrick Arbore, EdD, Center for Elderly Suicide Prevention and Grief Related Services, Institute on Aging</td>
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<td>Priorities, comments</td>
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<td><strong>Priorities, Comments</strong></td>
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<td>Patsy Hampton, WestEd Center for Prevention and Early Intervention</td>
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<tr>
<td>Ramona Davies, Northern California Presbyterian Homes and Services</td>
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<td><strong>Sacramento County</strong></td>
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<tr>
<td>Raul R. Sanchez</td>
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<tr>
<td><strong>Individual</strong></td>
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<td></td>
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<tr>
<td>Russell B Vergara, Multi-Ethnic Collaborative of Community Agencies</td>
<td>✓</td>
<td>Priorities, Comments</td>
<td>State-wide</td>
<td>Agency</td>
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</table>
## Appendix 4
### California Mental Health Services Authority (CalMHSA)

**CalMHSA 52-Day Stakeholder Input Process: Submissions by Organization, Individual and Locality**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategic Plans Submitted On</th>
<th>Priorities and/or Comments Submitted</th>
<th>Geographic Scope</th>
<th>Entity</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>S. Todd Stolp, M.D., Tuolumne County Health Department</td>
<td>✓ ✓ ✓</td>
<td>Priorities</td>
<td>Tuolumne County</td>
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</tr>
<tr>
<td>Sanjuana M. Ramos</td>
<td></td>
<td>Comments</td>
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<td>Individual</td>
<td>Individual</td>
</tr>
<tr>
<td>Serena Clayton, PhD, Executive Director California School Health Centers Association</td>
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<td>Priorities, comments</td>
<td>State-wide</td>
<td>Association</td>
<td>K-12</td>
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<tr>
<td>Sergio Aguilar-Gaxiola The California Latino Mental Health Concilio</td>
<td>✓ ✓ ✓</td>
<td>Priorities, comments</td>
<td>State-wide</td>
<td>Council</td>
<td>Latino Mental Health</td>
</tr>
<tr>
<td>Solano County MHSA Stakeholders</td>
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<td>Priorities, comments</td>
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<tr>
<td>Stacie Hiramoto Racial and Ethnic Mental Health Disparities (REMHDCO)</td>
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<td>Racial &amp; Ethnic Mental Health Consumers</td>
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<tr>
<td>Stephanie Welch, MSW California Mental Health Directors Association (CMHDA)</td>
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<td>Comments</td>
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<td>Association</td>
<td>Mental Health Services</td>
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<tr>
<td>Stewart Teal, M.D., President The California Academy of Child and Adolescent Psychiatry (Cal-ACAP)</td>
<td>✓ ✓ ✓</td>
<td>Priorities, comments</td>
<td>State-wide</td>
<td>Academy</td>
<td>Child and Adolescent Psychiatry</td>
</tr>
<tr>
<td>Sue Shrader-Hanes, MFT Mesa College Student Health Services</td>
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<td>Comments</td>
<td>Mesa College, San Diego</td>
<td>Community College</td>
<td>Community Colleges</td>
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## Stakeholder Input Process: Submissions by Organization, Individual and Locality

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Strategic Plans Submitted On</th>
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<th>Geographic Scope</th>
<th>Entity</th>
<th>Focus</th>
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<tbody>
<tr>
<td>Susan G. Keys, PhD, Inspire USA Foundation</td>
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<td>Priorities, comments</td>
<td>State-wide</td>
<td>Non-profit</td>
<td>Teens and young adults</td>
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<tr>
<td>Terri Restelli-Deits, Area Agency on Aging Serving Napa and Solano</td>
<td>✓</td>
<td>Priorities, Comments</td>
<td>Napa &amp; Solano Counties</td>
<td>Agency</td>
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<td>Unknown Individual</td>
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<tr>
<td>Viviana Criado, California Elder Mental Health and Aging Coalition</td>
<td>✓</td>
<td>Comments</td>
<td>State-wide</td>
<td>Coalition</td>
<td>Older Adults</td>
</tr>
<tr>
<td>Wesley K. Mukoyama, LCSW, Chairperson, Older Adults Committee, Santa Clara County Mental Health Board</td>
<td>✓</td>
<td>Priorities, comments</td>
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</table>
### Strategic Plans

**SUICIDE PREVENTION**

**STRATEGIC DIRECTION 1:**
Create a System of Suicide Prevention

<table>
<thead>
<tr>
<th>Recommended Action(s) at the <strong>State Level</strong></th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Org</td>
</tr>
<tr>
<td>1.1 Establish an Office of Suicide Prevention to provide coordination and collaboration across the state and serve as an online clearinghouse of information about suicide data and related research findings, best practices and community planning.</td>
<td>1</td>
</tr>
<tr>
<td>1.2 Engage a coalition of public partners to integrate, coordinate, enhance and improve policies and practices that prevent suicide. (list of partnerships)</td>
<td>4</td>
</tr>
<tr>
<td>1.3 Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide. (list of partnerships)</td>
<td>5</td>
</tr>
<tr>
<td>1.4 Convene and facilitate topic-specific working groups that will address specific populations and issues and develop, adapt and disseminate resources and other materials that address the topic.</td>
<td>3</td>
</tr>
<tr>
<td>1.5 Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level and enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.</td>
<td>1</td>
</tr>
<tr>
<td>1.6 Create a statewide consortium of suicide prevention hotlines. Explore opportunities to expand the reach of accredited suicide prevention hotlines through other communication means or technology such as Web-based sites.</td>
<td>2</td>
</tr>
<tr>
<td>1.7 Identify and implement needed improvements in confidentiality laws and practices to promote safety, health, wellness and recovery.</td>
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</tr>
</tbody>
</table>
### Appendix 5
California Mental Health Services Authority (CalMHSA)

**CalMHSA Stakeholder Submission Themes by Recommended Actions**

<table>
<thead>
<tr>
<th>Recommended Action(s) at the <strong>Local</strong> Level:</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Org</td>
</tr>
<tr>
<td>1.8 In each county, appoint a liaison to the state Office of Suicide Prevention and build upon an existing body or convene a new suicide prevention advisory council to collectively address local suicide prevention range of local stakeholders with expertise and experience with diverse at-risk groups. (list of inclusions)</td>
<td>1</td>
</tr>
<tr>
<td>1.9 Develop a local suicide prevention action plan with the input of a diverse, representative group of stakeholders, including the entity designated as the local suicide prevention advisory council.</td>
<td>2</td>
</tr>
<tr>
<td>1.10 Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions to reducing suicide.</td>
<td>1</td>
</tr>
<tr>
<td>1.11 Deliver services that reflect integration among systems providing crisis intervention, including health, mental health, aging and long-term care, social services, first responders and hotlines. Establish formal partnerships that foster communication and coordinated service delivery among providers from different systems.</td>
<td>2</td>
</tr>
<tr>
<td>1.12 Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace and the criminal and juvenile justice systems.</td>
<td>2</td>
</tr>
<tr>
<td>1.13 Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations.</td>
<td>5</td>
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<tr>
<td>1.14 Ensure that the county has at least one accredited suicide prevention hotline call center or that the county has a formal partnership with an accredited call center.</td>
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<tr>
<td>1.15 For counties with an established, accredited suicide prevention hotline call center, work with the Office for Suicide Prevention to explore opportunities to provide training and consultation to other counties to develop their suicide prevention hotline capacity.</td>
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</table>
**STRATEGIC DIRECTION 2:**
Implement Training and Workforce Enhancements to Prevent Suicide.

<table>
<thead>
<tr>
<th>Recommended Action(s) at the <strong>State Level:</strong></th>
<th>Submissions</th>
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</thead>
<tbody>
<tr>
<td>2.1 Convene expert workgroups to recommend, develop, disseminate, broadly promote and evaluate suicide prevention service and training guidelines and model curricula for targeted service providers, including peer support providers, in California.</td>
<td>8 8 0 0 16</td>
</tr>
<tr>
<td>2.2 Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, and graduate programs.</td>
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<tr>
<td>2.3 Following implementation of 2.1 and 2.2, develop and implement a process for determining within five years which occupations are to be targeted for required training and how the requirements will be implemented.</td>
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</table>

<table>
<thead>
<tr>
<th>Recommended Action(s) at the <strong>Local Level:</strong></th>
<th>Submissions</th>
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</thead>
<tbody>
<tr>
<td>2.4 Establish annual targets for suicide prevention training that identify the number of individuals and occupations that will receive training and the models, including peer support, which will be used for training. Using an inclusive process for input, develop and implement training plans that meet these targets.</td>
<td>1 5 0 1 7</td>
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<tr>
<td>2.5 Increase the priority of suicide prevention training through outreach and by disseminating, tailoring and enhancing state training guidelines as necessary to meet local needs.</td>
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</table>
### STRATEGIC DIRECTION 3:
Educate Communities to Take Action to Prevent Suicide.

#### Recommended Action(s) at the State Level:

<table>
<thead>
<tr>
<th>Recommended Action</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>3.1 Launch and sustain a suicide prevention education campaign with messages that</strong></td>
<td></td>
</tr>
<tr>
<td><strong>have been tested to be effective for diverse communities and that address warning</strong></td>
<td>6 8 0 0 14</td>
</tr>
<tr>
<td><strong>signs, suicide risk and protective factors and how to get help.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.2 Coordinate the suicide prevention education campaign with any existing social</strong></td>
<td>3 2 0 0 5</td>
</tr>
<tr>
<td><strong>marketing campaign designed to eliminate stigma and discrimination toward</strong></td>
<td></td>
</tr>
<tr>
<td><strong>individuals with mental illness and their families.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.3 Engage the news media and the entertainment industry to educate them on</strong></td>
<td>3 3 0 0 6</td>
</tr>
<tr>
<td><strong>standards and guidelines to promote balanced and informed portrayals of suicide,</strong></td>
<td></td>
</tr>
<tr>
<td><strong>mental illness and mental health services that support suicide prevention efforts.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.4 Promote information and resources about strategies that reduce access to lethal</strong></td>
<td>2 0 0 0 2</td>
</tr>
<tr>
<td><strong>means, such as gun safety education and increasing compliance with existing gun</strong></td>
<td></td>
</tr>
<tr>
<td><strong>safety laws, safe medication storage and physical and non-physical deterrent</strong></td>
<td></td>
</tr>
<tr>
<td><strong>systems on bridges or other high structures.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.5 Disseminate and promote models for suicide prevention education for community</strong></td>
<td>7 2 0 0 9</td>
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<tr>
<td><strong>gatekeepers.</strong></td>
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#### Recommended Action(s) at the Local Level:

<table>
<thead>
<tr>
<th>Recommended Action</th>
<th>Submissions</th>
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<tbody>
<tr>
<td><strong>3.6 Building grassroots outreach and engagement efforts to coordinate with and</strong></td>
<td></td>
</tr>
<tr>
<td><strong>tailor the statewide suicide prevention education campaign and activities to best</strong></td>
<td>1 3 0 0 4</td>
</tr>
<tr>
<td><strong>meet community needs.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>3.7 Create opportunities to promote greater understanding of the risks and</strong></td>
<td></td>
</tr>
<tr>
<td><strong>protective factors related to suicide and how to get help by engaging and educating</strong></td>
<td>0 2 0 0 2</td>
</tr>
<tr>
<td><strong>local media about their role in promoting suicide prevention and adhering to suicide</strong></td>
<td></td>
</tr>
<tr>
<td><strong>reporting guidelines.</strong></td>
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</table>
### Appendix 5
California Mental Health Services Authority (CalMHSA)
CalMHSA Stakeholder Submission Themes by Recommended Actions

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.8 Educate family members, caregivers and friends of those who have attempted suicide, individuals who have attempted suicide and community helpers to recognize, appropriately respond to and refer people demonstrating acute warning signs.</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>8</td>
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<tr>
<td>3.9 Promote and provide suicide prevention education for community gatekeepers.</td>
<td>3</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>3.10 Develop and disseminate directory information on local suicide prevention and intervention services that includes information about how and where to access services and how to deal with common roadblocks.</td>
<td>2</td>
<td>4</td>
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<td>0</td>
<td>6</td>
</tr>
<tr>
<td>3.11 Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.</td>
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<td>3</td>
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**STRATEGIC DIRECTION 4:**
Improve Suicide Prevention Program Effectiveness and System Accountability.

<table>
<thead>
<tr>
<th>Recommended Action(s) at the State Level</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Develop a California surveillance and research agenda on suicide, suicide attempts and suicide prevention to support data-driven policies and evidence-based programs.</td>
<td>2</td>
</tr>
<tr>
<td>4.2 Test and adapt evidence-based practices as necessary for effectiveness in a variety of community settings and among diverse population groups.</td>
<td>5</td>
</tr>
<tr>
<td>4.3 Identify or develop methodologies for evaluating suicide prevention interventions, including community-based participatory research methods and provide training and technical assistance on program evaluation to the counties and local partners. Develop methodologies to promote the evaluation of promising community models to build their evidence base. Use an inclusive process that considers cultural approaches, such as traditional healing practices and measures that are relevant to target communities.</td>
<td>4</td>
</tr>
</tbody>
</table>
4.4 Coordinate with the Office of Suicide Prevention and county suicide prevention liaisons to make data and reports more accessible to and in more user-friendly formats for, the public at large and policy makers at all levels to improve understanding of suicide and suicide attempts and to enhance prevention efforts for all population groups.

<table>
<thead>
<tr>
<th>Recommended Action(s) at the Local Level:</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5 Increase local capacity for data collection, reporting, surveillance and dissemination to inform prevention and early intervention program development and training.</td>
<td>0 1 0 1 2</td>
</tr>
<tr>
<td>4.6 Build local capacity to evaluate suicide prevention programs and use the results to make program improvements, including community-based participatory research methods.</td>
<td>0 2 0 0 2</td>
</tr>
<tr>
<td>4.7 Establish or enhance capacity for a clinical and forensic review of suicide deaths in each county. The suicide death review process should include reporting de-identified data and findings to the State Office of Suicide Prevention and the local suicide prevention advisory council at minimum. The advisory council could use the reports to inform local policy action recommendations. Members of the case review teams should include representative of the Office of the Coroner/Medical Examiner and as appropriate other officials with legal access to confidential information.</td>
<td>1 1 0 0 2</td>
</tr>
<tr>
<td>4.8 Work with coroners and medical examiners to determine how to enhance reporting systems to improve the consistency and accuracy of data about suicide deaths.</td>
<td>0 0 0 0 0</td>
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</tbody>
</table>

**STIGMA AND DISCRIMINATION REDUCTION**

**STRATEGIC DIRECTION 1:**
Creating a supportive environment for all consumers and those at risk for mental health challenges, family members and the community at large establishing social norms that recognize mental health is integral to everyone's well-being.
Appendix 5
California Mental Health Services Authority (CalMHSA)

CalMHSA Stakeholder Submission Themes by Recommended Actions

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis; and persons living with mental health challenges have resilience and the capacity for recovery.</td>
<td>5 3 1 0 9</td>
</tr>
<tr>
<td>1.2 Prevent the development of mental health stigma, stereotyping and discrimination.</td>
<td>1 0 0 0 1</td>
</tr>
<tr>
<td>1.3 Create opportunities and forums for strengthening relationships and understanding between consumers, family members and the larger community.</td>
<td>3 1 0 1 5</td>
</tr>
<tr>
<td>1.4 Reduce self-stigma of individuals living with mental health challenges and stigma by association for their family members.</td>
<td>4 4 0 0 8</td>
</tr>
<tr>
<td>1.5 Recognize peer-run and peer-led programs as an important means for reducing stigma.</td>
<td>6 2 0 1 9</td>
</tr>
<tr>
<td>1.6 Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.</td>
<td>6 4 1 0 11</td>
</tr>
<tr>
<td>1.7 Provide increased support for those closely involved with the lives of individuals facing mental health challenges.</td>
<td>6 2 1 0 9</td>
</tr>
<tr>
<td>1.8 Reduce the effects of stigma with a strength-based approach to assessment, diagnosis, treatment planning and interventions.</td>
<td>6 6 0 0 12</td>
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</tbody>
</table>
STRATEGIC DIRECTION 2:
Promoting awareness, accountability and changes in values, practices, policies and procedures across and within systems and organizations that encourage the respect and rights of people identified with mental health challenges.

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
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<tbody>
<tr>
<td>2.1 Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices and policies.</td>
<td>4</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>2.2 Establish developmentally appropriate prevention, recovery and wellness programs.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>2.3 Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.</td>
<td>7</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>2.4 Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.</td>
<td>6</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>2.5 Promote the dignity and safety of mental health consumers and their family members by training and educating law enforcement, first responders, other medical personnel and the community at large to reduce stigmatizing attitudes and discriminating behavior. Educate the public about community resources available to assist with mental health-related crises; utilize informed consent as a means to ensure voluntary choice; prepare and equip law enforcement to better respond to the needs of individuals in mental health-related crisis; and eliminate a perceived need for the use of force and forced compliancy through these and other systematic alternatives referred to earlier in this Plan.</td>
<td>6</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>11</td>
</tr>
<tr>
<td>2.6 Educate employers on the importance of mental health wellness for all employees.</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>
### 2.7 Expand opportunities for employment, professional development, upward mobility, retention and success of mental health consumers in public, nonprofit and private sector workplaces by enforcing current laws and challenging hiring biases.

<table>
<thead>
<tr>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>

### 2.8 Eliminate discriminatory barriers to better meet the housing needs of mental health consumers by: educating the general public, landlords and local officials on the rights and housing needs of mental health consumers and their families/caretakers; ensuring that all private and subsidized housing meets the nondiscrimination requirements of the Fair Housing Act and that their admissions procedures and management practices ensure all applicants and tenants have equal opportunities to benefit from the housing; encouraging supportive housing and other housing for individuals with disabilities to be well integrated throughout the community, accommodating of all levels of care; promoting the provision of housing first as one means to eliminating discriminatory barriers; and promoting the accessibility of services in housing.

<table>
<thead>
<tr>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
</tbody>
</table>

### 2.9 Engage and educate the commercial, ethnic, public/community and interactive media, as well as the entertainment industry, on standards and guidelines to promote balanced and informed portrayals of people living with mental health challenges; and ways to serve as a resource for communicating accurate and non-stigmatizing information to the public on mental health issues and community resources.

<table>
<thead>
<tr>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>6</td>
</tr>
</tbody>
</table>

### 2.10 Promote and enhance initiatives, programs and curricula to change school cultures and increase social inclusion and social acceptance.

<table>
<thead>
<tr>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
</tbody>
</table>

---

### STRATEGIC DIRECTION 3:

Upholding and advancing federal and state laws to identify and eliminate discriminatory policies and practices.

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Increase awareness and understanding of existing laws and regulations that</td>
<td>State Org</td>
</tr>
<tr>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>
protect individuals living with mental health challenges and their family members against discrimination.

<table>
<thead>
<tr>
<th>3.2 Promote the compliance and enforcement of current anti-discrimination laws and regulations.</th>
<th>2</th>
<th>2</th>
<th>0</th>
<th>1</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3 Work to enhance and/or amend current statutes and regulations to further protect individuals and their family members from discrimination.</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>3.4 Develop policies and mechanisms within the criminal justice system to more appropriately meet the needs of individuals with mental health challenges, including those located in in-patient psychiatric facilities.</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
</tbody>
</table>

**STRATEGIC DIRECTION 4:**
Increasing knowledge of effective and promising programs and practices that reduce stigma and discrimination using methods that include community-led approaches.

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>State Org</th>
<th>County Org</th>
<th>Regional Org</th>
<th>Individual</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Develop and implement a plan to address the information gaps on how to reduce stigma and discrimination to build effective and promising anti-stigma and anti-discrimination programs.</td>
<td>3</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>8</td>
</tr>
<tr>
<td>4.2 Increase the skills and abilities of community participants to evaluate programs.</td>
<td>1</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.3 Ensure that research and evaluation projects adapt and respond to community needs.</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>4.4 Disseminate the lessons learned, promising practices and other outcome findings.</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
</tbody>
</table>
STUDENT MENTAL HEALTH
STRATEGIC DIRECTION 1: HIGHER EDUCATION
Design and administer programs that will focus on three key strategic directions—training, peer support activities and suicide prevention—that can be implemented at any college, district, multi-campus collaborative, or system within each of the three California public higher education systems.

<table>
<thead>
<tr>
<th>Recommended Action(s)</th>
<th>Submissions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>State Org</td>
</tr>
<tr>
<td>1. Training: The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness and to promote a campus environment that enhances student success providing hope, supporting resiliency and creating a healthy learning community.</td>
<td>2</td>
</tr>
<tr>
<td>2. Peer-to-Peer Support: These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.</td>
<td>4</td>
</tr>
<tr>
<td>3. Suicide Prevention: These programs would be designed utilizing the resources and best-practices of the MHSA suicide prevention efforts or knowledge of the assigned workgroup but would focus specifically on addressing the unique needs, vulnerabilities and risk factors of university and college students and would bring suicide prevention resources directly onto campuses to raise their profile among students and to make them as accessible, relevant and effective as possible.</td>
<td>3</td>
</tr>
</tbody>
</table>
STRATEGIC DIRECTION 1: K-12

Design and administer programs that will focus on three key strategic directions—training, peer support activities and suicide prevention—that can be implemented at any college, district, multi-campus collaborative, or system within one of the three California public higher education systems. Four strategic directions should be incorporated into a comprehensive student mental health program funded by the SMHI.

Recommended Action(s) | Submissions
--- | ---
1. School-Based Programs: Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including: | State Org County Org School District Individual Total
--- | --- | --- | --- | --- | ---
• Efforts that foster supportive school climates including bullying prevention, suicide prevention, stigma reduction and cultural awareness.
• Mental health educational programs for students that include a focus on stigma reduction, incorporate age-appropriate suicide prevention training for the general student population and are in alignment with state Health Education Standards.
• Early identification of students with mental health concerns who seek help, including universal voluntary screenings in partnership with families and caregivers.
• Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs and community-based organizations.
• Outreach and education for families that are culturally and linguistically responsive and reduce the stigma associated with accessing and using mental health services.
• Consideration for youth from communities that demonstrate a high incidence of mental health problems or where research demonstrates a high risk for specific mental health needs, for example suicide risk among African-American and Caucasian males, Asian-American females, Hispanic males and
females, LGBTQ youth and Native American youth.

- Training for those personnel, like teachers, most likely to first identify potential mental health needs, which includes resources for identification, referral and non-stigmatizing responses.
- Use of appropriate youth peer-to-peer strategies.

### 2. Systems and Policy Developments: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include:

<table>
<thead>
<tr>
<th>Change Description</th>
<th>Count</th>
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<tbody>
<tr>
<td>Coordination and redirection of resources through school, district-wide, regional and/or statewide systems to create a cohesive and comprehensive system from prevention and early intervention to intervention and support for student mental health as opposed to fragmented programs.</td>
<td>4</td>
</tr>
<tr>
<td>Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.</td>
<td>7</td>
</tr>
<tr>
<td>Collaboration with community-based providers that enhance student success, for example health services, tutoring, after-school programs, or mentoring.</td>
<td>0</td>
</tr>
<tr>
<td>Development of policies within the school/district/region/state that make mental health promotion an integral part of school operations and school improvement efforts, for example disciplinary policies that are therapeutic.</td>
<td>2</td>
</tr>
<tr>
<td>Procedures for on-going assessment of student mental health and continuous improvement of school-based programs.</td>
<td>13</td>
</tr>
<tr>
<td>Involvement of pupil services personnel, including credentialed school counselors, school psychologists, school social workers, speech-language therapists and audiologists, resource specialists and school nurses where available, in the planning and executing of systems and policy changes.</td>
<td></td>
</tr>
<tr>
<td>Meet current state curriculum mandates for health and wellness.</td>
<td>14</td>
</tr>
</tbody>
</table>

### 3. Education and Training: School/district personnel should receive education and training to support the successful implementation of specific school-based programs:

<table>
<thead>
<tr>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
</tr>
<tr>
<td>6</td>
</tr>
<tr>
<td>0</td>
</tr>
<tr>
<td>1</td>
</tr>
<tr>
<td>14</td>
</tr>
</tbody>
</table>
programs as well as the systems and policy changes needed to sustain these programs.

4. Technical Assistance: In order to support the effective development of comprehensive student mental health programs, the SMHI will include funding for technical assistance to support program development and implementation through the provision of resources on best practices, convening to exchange and share information and lessons learned and access to on-site consultation to increase the effectiveness of SMHI-funded programs.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>13</td>
</tr>
</tbody>
</table>
The CalMHSA Implementation Work Plan for Statewide Prevention and Early Intervention was posted and distributed for an invitation to submit public comment on October 7, 2010. Comments were submitted for a 30 day period, starting October 7, 2010 and ending on November 6, 2010. Each comment submitted was reviewed by CalMHSA staff, work plan writer, and the Implementation Ad Hoc Committee Chair. Comments were reviewed for opportunity to enhance clarity and improve the Implementation Work Plan within the priority framework approved by the CalMHSA Board. Relevant sections were amended when suggested alternative phrasing added value or when a more specific description was indicated. The response column below identifies CalMHSA’s official response and the place in the document that was amended if any. There are no changes to the priorities for recommended actions approved by the CalMHSA Board, even though some comments requested that additional recommended actions be implemented. CalMHSA may consider additional recommended actions in the future as more funds become available. Following are the summarized comments, listed in order received. For a complete narrative of each comment, refer to Appendix 7. Below, the summarized public comment, CalMHSA Implementation Work Plan report section referenced, and CalMHSA response are provided. Due to the lateness of some comments, response placement in the work plan might shift slightly in the process of adding additional public responses to work plan.

<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public Comment Date: 10/08/2010</td>
<td>CalMHSA Draft Work Plan (10/07/2010): SMHI, pages 68 -69</td>
<td>Reference the following for inclusion: Page 65 (second paragraph); page 69 (Program Deliverables); page A2.28 (Program)</td>
</tr>
<tr>
<td>Subject: K-12 School Attendance Review Boards</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by: David Kopperud, California Department of Education</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
</tr>
<tr>
<td>2. Public Comment Date: 10/20/2010</td>
<td>CalMHSA Draft Work Plan (10/07/2010): SDR 1.1, 1.6, 2.9, page A4.3</td>
<td>Reference the following for inclusion: Pages 44, 49</td>
</tr>
<tr>
<td>Subject: Inclusion, Communication for Social Change Methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by: Philip Traynor, MPA, Radio Bilungüe</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Public Comment Date: 11/02/2010</td>
<td>CalMHSA Draft Work Plan (10/07/2010): SMHI, page 25</td>
<td>Reference the following for inclusion: Page 68 (first paragraph); and page A2.27 (Program Deliverables, first and third bullet)</td>
</tr>
<tr>
<td>Subject: Student Mental Health Initiative (SMHI)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by: Serena Clayton, Executive Director, California School Health Centers Association</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Public Comment Date: 11/02/2010</td>
<td>CalMHSA Draft Work Plan (10/07/2010): SP 2.2</td>
<td>Reference the following for inclusion: Page 36 (Program Deliverables, under ninth bullet); and page A2.13 (Program Deliverables) Page 50 Page 64 (fourth paragraph)</td>
</tr>
<tr>
<td>Subject: CalMHSA Statewide PEI Work Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by: California Primary Care Association (CPCA)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
</tr>
<tr>
<td>---</td>
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</tr>
<tr>
<td>5.</td>
<td>Public Comment Date: 11/02/2010  Subject: Student Mental Health Initiative and Higher Education  Submitted by: Marissa Lee, UCLA Alumni, UCLA Health Advisory Committee (2007-08), California Mental Health Planning Council Transition Age Youth Representative</td>
<td>SMHI K-12 1 and K-12 2</td>
</tr>
</tbody>
</table>
## Summary Public Comment Submissions to October 7, 2010

**CalMHSA Draft Implementation Work Plan**

<table>
<thead>
<tr>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planning Council is on several of the distribution lists. It is through these distribution lists that higher education participants were sought.</td>
<td></td>
</tr>
</tbody>
</table>

### 6. Public Comment Date: 11/03/2010

**Subject:** CalMHSA Statewide Prevention and Early Intervention Implementation Work Plan

Submitted by: Children and Youth Subcommittee (CYSOC) and the Transition Age Youth Subcommittee (TAY), of the California Mental Health Planning Council

**CalMHSA Draft Work Plan (10/07/2010)**

- SP 3.11, pages 34 and A2.5
- SDR 1.5, pages 50 and A2.9
- SDR2.4, page 5
- SMHI Higher Education, page 64

Reference the following for inclusion:

- Page 32 (Program Deliverables, first bullet); and page A2.9 (program deliverables, first bullet)
- Page 47 (second paragraph, second bullet); and page A2.19 (first paragraph, eighth bullet)
- Page 51 (Program Deliverables, seventh bullet) and page A2.22 (first paragraph, third bullet)
- Page 60 (third paragraph) and page A2.26 (Program Deliverables, fifth bullet)
### Summary Public Comment Submissions to October 7, 2010

**CalMHSA Draft Implementation Work Plan**

<table>
<thead>
<tr>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMHI 1, page A4.5</td>
<td>Page 60 (fourth paragraph)</td>
</tr>
<tr>
<td>SMHI 2, page A4.5</td>
<td>Page 61 (first paragraph)</td>
</tr>
</tbody>
</table>

7. **Public Comment Date:** 11/04/2010

**Subject:** CalMHSA Work Plan for State Prevention and Early Intervention Work Plan, Transition Age Youth (TAY) and Transition Age Foster Youth (TAFY)

**Submitted by:** Crandall Phillip, Humboldt County Department of Health and Human Services

**CalMHSA Draft Work Plan (10/07/2010):**

- TAY and TAFY as target populations
- Inclusion in planning and implementation
- Methods matched to evidence-based practices
- TAY providers included in developing marketing, training, etc.

**Reference the following for inclusion:**

- Page 4 (fifth bullet); page 12 (under seventh bullet); page 61 (first bullet); page A2.3 (eighth bullet); and page A2.17 (first bullet)
- Page 20 (last paragraph, first sentence); and page A2.7 (Program Deliverables, first bullet)
- Page 32 (Program Deliverables, first bullet); page 65 (second bullet); page 68 (under first bullet); and page A2.26 (under third bullet)
## Summary Public Comment Submissions to October 7, 2010
### CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Public Comment Date: 11/04/2010</td>
<td>Reference the following for clarification/explanation:</td>
</tr>
<tr>
<td>Subject: CalMHSA Work Plan for State Prevention and Early Intervention Work Plan</td>
<td>The budget included in the September 27 draft plan included the planning dollars of $6.8 million included in the allocation to each of the programs for a total budget of $136.2 million. Subsequent to the issuance of the September 27, 2010 draft, staff met with MHSOAC staff and determined the budget submitted in the implementation plan should only include the Phase II Funding request as was defined in Information Notice 10-06. Phase II funding request (implementation plan) does not include the planning money. The planning money of $6.8 million has been requested by each</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
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<tr>
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<tr>
<td></td>
<td>Page 7 and page 11</td>
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<tr>
<td></td>
<td>Page 18 and page 31</td>
</tr>
<tr>
<td></td>
<td>Appendix 2, page A2.1</td>
</tr>
</tbody>
</table>
## Summary Public Comment Submissions to October 7, 2010

<table>
<thead>
<tr>
<th>CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. Public Comment Date: 11/05/2010</td>
<td>CalMHSA Draft Work Plan (10/07/2010):</td>
<td>Reference the following for inclusion:</td>
</tr>
<tr>
<td>Subject: Work Plan Comments</td>
<td>Page 12</td>
<td>Page 11 (first and sixth bullet)</td>
</tr>
<tr>
<td>Submitted by: Michael Gardner, Stephanie Thal, MFT, CA Mental Health Planning Council</td>
<td>Page 13</td>
<td>Page 12 (last bullet)</td>
</tr>
<tr>
<td></td>
<td>Page 17</td>
<td>Page 18 (first paragraph)</td>
</tr>
<tr>
<td></td>
<td>Page 18</td>
<td>Page 21 (Program Deliverables, sixth bullet)</td>
</tr>
<tr>
<td></td>
<td>Page 30</td>
<td>Page 33 (second bullet)</td>
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<tr>
<td></td>
<td>Page 33</td>
<td>Page 32 (third paragraph)</td>
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<td></td>
<td>Page 38</td>
<td>Page 46 (seventh paragraph)</td>
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<td>Page 48</td>
<td>Page 47 (last paragraph)</td>
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<tr>
<td></td>
<td>Page 49</td>
<td>Page 46 (third bullet)</td>
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<tr>
<td></td>
<td>Page 50</td>
<td>A2.18 (last paragraph and third bullet) A2.19 (sixth bullet)</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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</tr>
<tr>
<td>CalMHSA Draft Implementation Work Plan</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 10. Public Comment Date: 11/05/2010  
Subject: Comments on CalMHSA Implementation Work Plan  
Submitted by: Chad Silva, Statewide Policy Analyst, Latino Coalition for a Healthy California | CalMHSA Draft Work Plan (10/07/2010):  
SMHI K-12, Recommended Action 1 | Reference the following for inclusion:  
Page 64 (first paragraph); and page A3.8 (third and fourth bullets) |
| 11. Public Comment Date: 11/06/2010  
Subject: Comments on Implementation Work Plan, Stigma and Discrimination Reduction and Student Mental Health Initiative  
Stigma & Discrimination Reduction, page 45, second paragraph  
Page 48 (Program Description, fifth paragraph)  
Page 50 (after last bullet)  
Appendix 2, Page A2.15 (before Priority 1)  
Appendix 2, page A2.18 | Reference the following for inclusion:  
Page 41 (second paragraph)  
Page 45 (Program Description, fifth paragraph)  
Page 48 (second bullet)  
Appendix 2, page A2.16 (second paragraph)  
Appendix 2, page A2.17–A2.18 |
## Appendix 6
California Mental Health Services Authority (CalMHSA)
Draft Implementation Work Plan Comments and Responses

<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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<tr>
<td></td>
<td>(Program Deliverables, first, third, seventh and ninth bullet)</td>
<td>(Program Deliverables, first, third, seventh and ninth bullet)</td>
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<td></td>
<td>Student Mental Health Initiative, page 64 (Training section)</td>
<td>Student Mental Health Initiative, page 60 (Training section, second paragraph)</td>
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<td></td>
<td>Page 64 (Peer to Peer Support)</td>
<td>Page 61 (Peer to Peer Support, first paragraph)</td>
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<td></td>
<td>Page 67 (K-12 Policy Development section, first paragraph)</td>
<td>Page 64 (K-12 Policy Development section, first paragraph)</td>
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<td></td>
<td>Page 68 (under K-12 Regional Program)</td>
<td>Page 64 (under K-12 Regional Program, first paragraph)</td>
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<td></td>
<td>Page 69 (School-based programs)</td>
<td>Page 66 (fourth bullet)</td>
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<tr>
<td></td>
<td>Page A2.24 (Program Deliverables, second and third bullet)</td>
<td>Page A2.26 (Program Deliverables, second and fourth bullet)</td>
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<tr>
<td></td>
<td></td>
<td>Page A2.27 (Program Deliverables, second and third bullet)</td>
</tr>
</tbody>
</table>
## Summary Public Comment Submissions to October 7, 2010
CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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<tbody>
<tr>
<td>Page A2.25</td>
<td>Deliverables, first and second bullet</td>
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<tr>
<td>Page A2.27</td>
<td>Page A2.28 (Program Deliverables, top of page)</td>
</tr>
</tbody>
</table>

### 12. Public Comment Date: 11/06/2010
Subject: Comments on the CalMHSA Statewide PEI Implementation Work Plan
Submitted by: Glenda Lingenfelter, Interim, Mental Health Deputy Director, Solano County Health & Social Services Department

CalMHSA Draft Work Plan (10/07/2010):
Inclusion of additional recommended actions

Reference the following for inclusion:
For recommended actions were not prioritized for implementation, CalMHSA may consider additional recommended actions if additional funding becomes available (see Introduction section for recommended actions selection procedures)

See age 61 (Solano previously listed in Region 4)
<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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<tbody>
<tr>
<td>CalMHSA Draft Implementation Work Plan</td>
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<tr>
<td>13. Public Comment Date: 11/06/2010</td>
<td></td>
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<tr>
<td>Subject: NAMI Comments on the CalMHSA Statewide PEI Implementation Work Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Submitted by: Kathleen Derby, MHSA Policy Coordinator, National Alliance on Mental Illness (NAMI)</td>
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</tr>
<tr>
<td></td>
<td>CalMHSA Draft Work Plan (10/07/2010):</td>
<td>Reference the following for inclusion:</td>
</tr>
<tr>
<td></td>
<td>Introduction sections of work plan (pages 1-10):</td>
<td>In general, comments that are not specific to the work plan will be noted by CalMHSA, but responses will not be reflected in the work plan</td>
</tr>
<tr>
<td></td>
<td>Need for continued development of Stakeholder Engagement Process</td>
<td></td>
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<tr>
<td></td>
<td>Need to clearly define the Ad Hoc Implementation Committee (pages 3-4)</td>
<td></td>
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<tr>
<td></td>
<td>CalMHSA Membership Expansion and Statewide Effect</td>
<td></td>
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<td></td>
<td>Principles and Policy Directions for</td>
<td></td>
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<tr>
<td></td>
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<td>Reference pages 1-4 of work plan</td>
</tr>
<tr>
<td></td>
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<td>Reference Appendix 1, Budget</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<td></td>
<td>Implementation (page 5) Suicide Prevention (pages 11-14); and coordination between DMH and CalMHSA</td>
<td>Reference the Suicide Prevention section of this report for CalMHSA and Office of Suicide Prevention coordinated plans, and Appendix 2 Recommended Action 1.2 was not selected as it was determined that the general implementation of the work plan would achieve integration, coordination, enhancement and improving policies, particularly with the development of a network of public and private organizations public and private organizations to develop and implement strategies to prevent suicide; and the linkage of this</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section REFERENCED</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<td></td>
<td>Recommended Action SP 1.5 and SP 1.6: Recommendation of recognition and linkage with hotlines and crisis centers network to existing networks. Though this recommended action SP 1.2 was not prioritized for implementation, CalMHSA may consider additional recommended actions if additional funding becomes available.</td>
</tr>
</tbody>
</table>

The purpose of the Regional and Local Suicide Prevention Capacity-Building Program is to expand the number and capacity of accredited local suicide prevention lines. This program would also require that each suicide prevention line join a consortium of publicly funded Suicide Prevention call centers; Identify and implement strategies to expand resources.
<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommended Action SDR 1.5: Increased support for those closely involved with the lives of individuals facing mental health challenges – work plan outline seems vague; and nontraditional community locations should be identified for the distribution of information—this deliverable should be expanded and funds</td>
<td></td>
<td>and services for accredited suicide prevention hotlines, such as training centers and aftercare services (page 25, Priority One) This will be addressed as an expectation of the RFP Scopes of Work</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<tr>
<td></td>
<td>secured</td>
<td>This is addressed through Peer-to-peer interventions -- assess, develop and disseminate information on peer-run and peer-led programs and social support models</td>
</tr>
<tr>
<td></td>
<td>There is no deliverable outlined in this section that emphasizes the need for providing family member to family member education and support for those in need Student Mental Health, pages 61-71, suggested change</td>
<td>Suggested change integrated on page 60</td>
</tr>
<tr>
<td></td>
<td>This is an over-arching philosophy of the SMHI for both higher education and K-12 and is expressed in the narrative of SMHI program descriptions and deliverables</td>
<td></td>
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<tr>
<td>Summary Public Comment Submissions to October 7, 2010</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<td>--------------------------------------------------------</td>
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<tr>
<td>CalMHSA Draft Implementation Work Plan</td>
<td>together the programs that will work best for them</td>
<td>Reference the following for inclusion:</td>
</tr>
<tr>
<td>Subject: Comments on the CalMHSA PEI Work Plan</td>
<td>Page 5 (MHSOAC PEI Principles and Policy Directions)</td>
<td>Page 11 (Outcomes, first and second bullets)</td>
</tr>
<tr>
<td>Submitted by: Lin Benjamin, MSW, MHA, Geriatric Mental Health Specialist, CA Department of Aging (CDA)</td>
<td>Page 12 (Outcomes, Suicide Prevention)</td>
<td>Page 12 (First and third bullets)</td>
</tr>
<tr>
<td></td>
<td>Page 13 (Second bullet from bottom of page)</td>
<td>Page 22, 23 (SP 1.12)</td>
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<td></td>
<td>Page 15, 16 (SP 1.12)</td>
<td>Page 16 (SP 1.3, 1.4, second paragraph)</td>
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<td>Page 16 (SP 1.3, 1.4, second paragraph)</td>
<td>Page 18 (SP 1.3, 1.4, last paragraph)</td>
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<tr>
<td></td>
<td>Page 17 (SP 1.3, 1.4, last paragraph)</td>
<td>Page 18 (SP 1.3, 1.4, last paragraph)</td>
</tr>
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<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
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<td></td>
<td>Program Deliverables, first bullet)</td>
<td>paragraph)</td>
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<td></td>
<td>Page 18 (SP 1.3, 1.4, Program Deliverables, second bullet)</td>
<td>Page 18 (SP 1.3, 1.4, Program Deliverables, first bullet)</td>
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<tr>
<td></td>
<td>Page 20 (SP 1.11, 1.13, Program Description, first paragraph)</td>
<td>Page 18 (SP 1.3, 1.4, Program Deliverables, second bullet)</td>
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<tr>
<td></td>
<td>Page 20 (SP 1.11, 1.13, Program Deliverables, first bullet)</td>
<td>Page 20 (SP 1.11, 1.13, Program Description, first paragraph)</td>
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<tr>
<td></td>
<td>Page 20, 21 (SP 1.11, 1.13, Program Deliverables, third bullet)</td>
<td>Page 21 (SP 1.11, 1.13, Program Deliverables, second bullet)</td>
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<tr>
<td></td>
<td>Page 29 (SP 3.2, 3.3, 3.7, Program Description, first paragraph)</td>
<td>Page 21 (SP 1.11, 1.13, Program Deliverables, sixth bullet)</td>
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<tr>
<td></td>
<td>Page 30 (SP 3.2, 3.7, Program Deliverables, Program Description, first paragraph)</td>
<td>Page 29 (SP 3.2, 3.3, 3.7, Program Description, first paragraph)</td>
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## Appendix 6
California Mental Health Services Authority (CalMHSA)  
Draft Implementation Work Plan Comments and Responses

<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>third bullet) Page 33 (SP 3.8, 3.9, 3.11, Program Description, fourth paragraph) Page 34 (SP 3.8, 3.9, 3.11, Program Deliverables, first bullet) Page 34 (SP 3.8, 3.9, 3.11, Program Deliverables, fourth bullet) Page 38 (SP 2.1, 2.2, 2.5, Program Deliverables, third bullet)</td>
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</tbody>
</table>
## Appendix 6
California Mental Health Services Authority (CalMHSA)
Draft Implementation Work Plan Comments and Responses

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<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
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<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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</thead>
<tbody>
<tr>
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<td>Page 39 (SP 3.8, 3.9, 3.11, Program Description, second paragraph, last sentence)</td>
<td>Program Deliverables, third bullet</td>
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<td>Page 40 (SP 3.8, 3.9, 3.11, Program Deliverables, second bullet)</td>
<td>Page 32 (SP 3.8, 3.9, 3.11, Program Description, third paragraph)</td>
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<td></td>
<td>Page 44 (SP 4.2, 4.3, 4.5, 4.6, Program Deliverables, first bullet)</td>
<td>Page 33 (SP 3.8, 3.9, 3.11, Program Deliverables, second bullet)</td>
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<td>Page 49 (SDR 1.1, 1.3, 1.5, 1.6, 1.7, Program Description, second bullet)</td>
<td>Page 40 (SP 4.2, 4.3, 4.5, 4.6, Program Deliverables, sixth bullet)</td>
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<td>Page 50 (SDR 1.1, 1.3, 1.6, 1.7, Program Description, third bullet)</td>
<td>Page 46 (SDR 1.1, 1.3, 1.5, 1.6, 1.7, Program Deliverables, third bullet)</td>
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<td>Page 50 (SDR 1.1, 1.3, 1.6, 1.7, Program</td>
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<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
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</tbody>
</table>
| 15. Public Comment Date: 11/06/2010  
Subject: Work Plan Comments  
Submitted by: Monica Nepomuceno, Consultant, California Department of Education | CalMHSA Draft Work Plan (10/07/2010):  
Page 66  
Page 67  
Page 68 | Reference the following for inclusion:  
Page 59: Clarification previously made: University and College Student Mental Health Program (UCSMHP)  
Page 62 (second paragraph revision); and page 67 and A2.1 (corrected) |
### Summary Public Comment Submissions to October 7, 2010

**CalMHSA Draft Implementation Work Plan**

<table>
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<th>Section Referenced</th>
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<tbody>
<tr>
<td>Page 69</td>
<td>Page 64 (third paragraph)</td>
</tr>
<tr>
<td>Page 70</td>
<td>Page 67 (seventh bullet)</td>
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</tbody>
</table>

#### 16. Public Comment Date: 11/06/2010

**Subject:** CAYEN Comments on the CalMHSA Statewide PEI Implementation Work Plan

**Submitted by:** Amber Burkan, Director

CA Youth Empowerment Network

**CalMHSA Draft Work Plan (10/07/2010):**

- Appendix 2:
  - Priority 1, add cultural groups across the lifespan
  - Recommended Action SP 1.3 (A2.1) -- Program Deliverables
  - Recommended Action SP 1.4 (A2.2) -- Program Deliverables
  - Recommended Action SP 1.13 (A2.3)

**Reference the following for inclusion:**

Most recommendations have been integrated into Appendix 2, and into the SP, SDR and SMHI work plan sections. However, Recommended Actions language cannot be modified in this work plan.
<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
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<tbody>
<tr>
<td></td>
<td>1.12 (A2.3) – Program Deliverables</td>
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<td>Recommended Action SP 3.9 (A2.9) – Program Deliverables</td>
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<td>Recommended Action SP 2.2 (A2.12) – Program Deliverables</td>
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<td>Recommended Action SP 2.5 (A2.13) – Potential outcomes/indicators</td>
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<td>Recommended Action SP 4.3 (A2.13)</td>
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<td>Recommended Action SDR 1.7 (A2.16) – Program Deliverables</td>
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<td>Recommended Action SDR 1.7 (A2.17)</td>
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<td>Priority Two (A2.19)</td>
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<td>Program Deliverables</td>
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<td>Recommended Action SDR 3.4 (A2.22)</td>
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<td>Priority Four Potential Outcomes (A2.22)</td>
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<tr>
<td>Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention (A2.24)</td>
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<td>Theme and Priority: Higher Education</td>
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<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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</table>
| Public Comment Date: 11/06/2010  
Subject: CEMHAC Comments on the CalMHSA Statewide PEI Implementation Work Plan  
Submitted by: Viviena Criedo, Executive Director  
CA Elder Mental Health and Aging Coalition CEMHAC) | Training, Peer Support and Suicide Prevention Goals: (A2.24) | Reference the following for inclusion:  
Appendix 1, Budget |

This deliverable has been previously addressed through other public comments (particularly public comments/responses for #9 listed above) and is integrated throughout the Suicide Prevention and Stigma and Discrimination Reduction.
<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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<tbody>
<tr>
<td>literacy levels. To establish age specific outcomes for each of the projects. For OA, SP and SDR include: Reducing Isolation Reducing incidence of depression Increasing self-management / coping skills to manage chronic and terminal conditions Increasing family/caregiver support Reducing stigma Reducing ageism</td>
<td>Page 32 (fourth paragraph) Reference Suicide Prevention deliverables and expected outcomes Reference Appendix 2 for Evaluation baseline and SP and SDR implementation work plans This is addressed in peer-to-peer components across all three initiatives This is addressed in peer-to-peer components</td>
<td></td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<tr>
<td>Reducing disparities in health care</td>
<td>Reference entire SDR section</td>
<td></td>
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<tr>
<td>Overall Plan: Revise plan for consistency across all parts</td>
<td>Reference SP &amp; SDR life span inserts</td>
<td></td>
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<tr>
<td>Clearly state goal developmentally appropriate, gender sensitive, ethnic and culturally/linguistically, geographic diverse (rural)</td>
<td>This is addressed in the SP section</td>
<td></td>
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<tr>
<td>Define role of DMH</td>
<td>Overview: pages 2, 3</td>
<td></td>
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<tr>
<td>Statewide Framework for Implementation of PEI Plans: page 5</td>
<td></td>
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<tr>
<td>Suicide Prevention (pages 10-13 and 18); and coordination between DMH and CalMHSA</td>
<td></td>
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<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
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</table>
| **18.** Public Comment Date: 11/07/2010  
Subject: Comments on Proposed PEI Statewide Implementation Work Plan of October 7, 2010  
Submitted by: California Network of Mental Health Clients | CalMHSA Draft Work Plan (10/07/2010):  
Page 4-6, PEI Principles  
Priority One: Recommended Actions  
SP 1.8, SP 1.9 and SP 1.9 | Reference the following for inclusion:  
Page 4, second and third bullets  
These recommended actions were not prioritized for implementation. CalMHSA may consider additional recommended actions if |

Prevention, Aging and Long Term Care, PH, CJ, SAMHSA, etc. involved in each project  
Add to the deliverables for all priorities, outcome tracking, monitoring, evaluation and reporting  
Appendix 8: DMH contract link  
Appendix 2, Program Evaluation
<table>
<thead>
<tr>
<th>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
<th>Section Referenced</th>
<th>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</th>
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</thead>
<tbody>
<tr>
<td>Appendix 2, Recommended Action SP 1.3 (page A2.1)</td>
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<td>additional funding becomes available</td>
</tr>
<tr>
<td>Recommended Action SP 1.12; and inclusiveness of consumers, family members, etc.</td>
<td></td>
<td>Page A2.1, second bullet</td>
</tr>
<tr>
<td>Recommended Actions SP 1.9, SP 3.6, SDR 1.4, SDR 1.8, SDR 2.5, SDR 2.7, 3.2, and SDR 3.3</td>
<td></td>
<td>Page 22 for recommended action SP 1.12</td>
</tr>
<tr>
<td>Prioritization of Recommended Actions</td>
<td></td>
<td>Page 23, seventh bullet</td>
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<tr>
<td></td>
<td></td>
<td>These recommended actions were not prioritized for implementation. CalMHSA may consider additional recommended actions if additional funding becomes available</td>
</tr>
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<td></td>
<td></td>
<td>Additional opportunities for the prioritization of recommended actions</td>
</tr>
<tr>
<td>Summary Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
<td>Section Referenced</td>
<td>CalMHSA Response (see November 12, 2010 Final Implementation Work Plan)</td>
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<td>------------------------------------------------------------------------------------------</td>
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<tr>
<td></td>
<td>Suicide Prevention Priority 4, inclusiveness of consumers, underserved cultural groups, etc.</td>
<td>actions will be made available through the CalMHSA RFP development process and suggestions made from public comments will be included for consideration and inclusion Page 40, second bullet</td>
</tr>
</tbody>
</table>
One of the critical methods for providing linkages to services in K-12 education that should be included on pages 68 to 69 of the CalMHSA Implementation Work Plan is the school attendance review board (SARB) process created by state statute (Education Code sections 48320 to 48325). In California, students with persistent school attendance or school behavior problems are referred to SARBs when the normal avenues of counseling and intervention do not resolve the problem. When SARB members meet with referred students and their parents or guardians, it is crucial that a representative with mental health expertise is present to help in identifying a solution or appropriate resources for the pupil and family. SARBs provide a natural infrastructure for addressing mental health needs in K-12 education because they function to identify and link children with persistent attendance and behavior problems and their families to all appropriate school and community resources, including mental health resources. Effective SARBs involve families and youths in selecting services and resources and in developing solutions to problems which interfere with education. SARBs provide an opportunity to garner the support a student needs to stay in school and regain access to the standards and learning and should be a part of the CalMHSA Work Plan leveraged to achieve equity and access for all children. Information about SARBs is available at http://www.cde.ca.gov/ls/ai/sb/. A small number of model SARBs, which excel at garnering support for high-risk youth, are recognized annually by the California Department (sic) of Education.
An effective radio campaign is designed to bring about positive change in the listeners' knowledge and understanding of mental health leading to the reduction of cultural barriers, stigma and discrimination. The traditional understanding of the role of communication is one that seeks mainly to change individual behaviors. That kind of communication can be defined as a process of understanding the concerns of communities, developing messages that respond to those concerns, and using media to persuade people to increase their knowledge and change the behaviors and practices that place them at risk. The assumption is that there are those who know what the problems and solutions are – the experts, and they need to communicate their wisdom to the community in order to bring about change. This process assumes the following:

- People are objects of change.
- Experts are the agents of change.
- Individual behavior must be changed.
- The process will be dominated by “outside” technical experts.

Communication for Social Change, on the other hand, is defined as a process of public and private dialogue through which people define who they are, what they want and how they can get it. Change is defined as change in people’s live as they themselves define such change. This work seeks particularly to improve the lives of the politically and economically marginalized, and is informed by principles of tolerance, self-determination, equity, social justice and active participation for all.
This approach is designed to rebalance strategic approaches to communications and change by shifting the overriding emphasis

- Away from people as objects for change ... and on to people and communities as the agents of their own change.

- Away from designing, testing, and delivering messages ... and on to supporting dialogue and debate on the key issues of concern.

- Away from the conveying of information from technical experts ... and on to sensitively placing that information into dialogue and debate.

- Away from a focus on individual behavior ... and on to norms, policies, culture and a supportive environment.

- Away from persuading people to do something ... and on to negotiating the best way forward in a partnership process.

- Away from technical experts in “outside” agencies dominating and guiding the process ... and on to the people most affected by the issues playing a central role.

Sustainability of change is more likely if the individuals and communities most affected own the process and content of the communication. That will happen to the extent that the communication for social change is empowering, horizontal [versus top-down], gives voice to the previously unheard members of the community and is biased toward local content and ownership.

What page numbers and sections numbers of the workplan does your comments refer to:

Mostly Page A4.3. Recommended action include: SDR 1.1; 1.5;1.6; and2.9.
Submitted by: Serena Clayton, Executive Director, California School Health Centers Association

Section Referenced: SMHI, page 25

Date: November 2, 2010

To: CalMHSA

From: Serena Clayton, Executive Director, California School Health Centers Association

Re: Comments on SMHI, page 25 of the PDF

- A statewide advisory body that convenes and staffs a “Student Mental Health Policy Workgroup” and oversees statewide coordination of K-12 programs across the Superintendent Regions

I strongly support a statewide body to look at policy issues and funding for student mental health but I’m not sure the phrase “coordination of K-12 programs” really captures that. There isn’t really a reason that these programs need to “coordinate” per se. Also I’m not sure if this refers to SMHI-funded K-12 programs or any K-12 mental health program (of which there are many). I would suggest this rewrite:

- A statewide advisory body that:

  - Convenes and staffs a “Student Mental Health Policy Workgroup”

  - Advises on development of the SMHI grant program
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

- A Regional K-12 responsible for school-based programs, technical assistance, education and training across regional programs

I’m not sure what this means. “a regional k-12”?

- School-Based Programs, including K-12 SMHIP, that provide a continuum of prevention and early intervention services including:
  - Linkages to services provided on campus or otherwise provided through school health centers, county departments of mental health, special education programs and community-based organizations
  - Linkages to services that are inclusive of county/local California Department of Education School Attendance Review Boards (SARBs)
  - Use of appropriate youth peer-to-peer strategies: school-based peer-to-peer programs that include combinations of campus-based and online tools

This looks great. I believe this is the grant funded programs which make up the bulk of the SMHI funds. You might specify: Grants for school-based programs...

- Technical assistance to bring together expertise with various organizations and to support program development and implementation

Also great.
CPCA Comments on the California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan

The California Primary Care Association (CPCA) represents over 800 community clinics and health centers that provide comprehensive primary health care services to nearly 4 million ethnically diverse patients of which 82% have incomes under 200% of the federal poverty level.

Community-based organizations, such as community clinics and health centers (CCHCs), are often the first line of defense for detection and treatment of mental health issues, and are the first point of contact for identifying and treating individuals who otherwise might face stigma, cultural, or other barriers to accessing traditional mental health services. CCHCs provide a wide range of mental health services in the primary care setting, and unlike entering the traditional mental health system, patients who seek help at their medical home, do so without the fear of stigma, in a culturally-competent environment where they already have a long-standing sense of familiarity and trust.
Please find attached our comments on the California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan. CPCA thanks CalMHSA for the opportunity to comment and commends the Board for including strategies and actions that foster the critical integration of primary health care and mental health services.

Please do not hesitate to contact us with any questions or concerns.

Sincerely,
Carmela Castellano-Garcia, Esq.
President and Chief Executive Officer
California Primary Care Association

CPCA Comments on the California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan

Suicide Prevention

Recommended Action 2.2: Expand opportunities for suicide prevention training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, and graduate programs.

Target professionals across systems and disciplines in their curriculum development efforts. At a minimum, occupations selected for guidelines and curricula development and training should include:

- Primary care providers, including physicians and mid-level practitioners
- First responders...
- Licensed mental health and substance abuse treatment professionals and staff in outpatient and community-based settings as well as psychiatric facilities
Social workers and other staff in older adult programs, in-home support services, adult and child protective services, and foster care.

CPCA strongly supports the inclusion of Recommended Action 2.2 in the final work plan and requests that community clinics and health centers be identified as a target group of primary care providers, including the licensed mental health and substance abuse treatment professionals that work within the CCHC setting. Community-based organizations, such as CCHCs, are often the first line of defense for detection and treatment of mental health issues, and are the first point of contact for identifying and treating individuals who otherwise might face stigma, cultural, or other barriers to accessing traditional mental health services. CCHCs provide a wide range of mental health services in the primary care setting and represent a prime opportunity for suicide prevention efforts because individuals generally visit their primary care provider about four times per year.

Stigma and Discrimination Reduction

**Recommended Action 2.3: Ensure that mental health services are offered in non-traditional, non-stigmatizing community and school sites.**

CPCA strongly supports the inclusion of Recommended Action 2.3 in the final work plan and requests clarification to ensure that organizations and provider sites not traditionally involved in the mental health system are encouraged under this plan, because these are often the places where individuals face the least stigma when accessing services. For example, seeking mental health services in a primary care clinic is a vital alternative because stigma in seeing your primary care provider is practically non-existent.

a) CPCA requests this item be clarified to better define „non-traditional, non-stigmatizing community sites” and give appropriate examples. We suggest doing so with language that is consistent with what the guidelines for the Mental Health Services Act Prevention and Early Intervention Component outline on this topic, including:

b) “…organizations and systems where people in the community currently go for purposes other than mental health
treatment services.” (Enclosure 1, Page 8)

c) “Programs are generally delivered in a natural community setting (e.g., tribal/Native American center, refugee resettlement agency, infant/toddler programs, preschool and school, family resource center, juvenile justice probation department, comprehensive services for home-bound older adults, primary health care, community clinic or health center, community-wide wellness center).” (Enclosure 1, Page 8)

Recommended Action 2.4: Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care, and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.

CPCA strongly supports Recommended Action 2.4 and cannot stress enough the tremendous efforts community clinics and health centers have and will continue to go through to operate under the widely revered Integrated Behavioral Health Care model. Only half the population suffering from diagnosable behavioral health disorders seek any form of behavioral health care and of the half that do seek care, 50% receive it solely in the primary care setting. Because most people seek primary care services a few times each year, primary care providers have unparalleled opportunities to identify behavioral health problems early and intervene in a manner that prevents further deterioration and avoids significant future costs.

Achieving coverage and financing parity between medical and mental health services is not only important to sustain and encourage high-quality mental health services, but in addition, many studies suggest that the provision of behavioral health services is a major medical cost containment strategy, with cost savings in the vicinity of 20-40%. Psychologists, therapists, counselors, social workers, and other mental health providers play an integral role in helping people modify their behavior to prevent and recover from health problems. People can reduce their risk of developing a major medical illness, receive more effective treatment, and reduce their health care costs when they seek treatment from an interdisciplinary primary care team.
CPCA requests the simplistic term “integrative delivery models” be supported with concrete, operational examples to demonstrate the many different forms integrated delivery may take, ranging from providing educational resources to primary care clinicians to facilitate specialist referrals, to co-locating mental and physical health clinicians in the same office. Co-location can be critical to ensuring mental health needs are addressed as early as possible. When, for example, during the course of a visit a primary care provider identifies a patient as needing further mental health assessment or services, he or she should be able to call on an in-house mental health provider to make a more formal assessment and, if indicated, affect a treatment plan on the same day. Unfortunately, within federally qualified health centers (FQHCs) and rural health clinics (RHCs) there remains a reimbursement barrier to providing these two visits on the same day, despite it being the best way to ensure patients receive the care they need in a timely manner.

**Student Mental Health Initiative: Kindergarten through Twelfth Grade**

*Recommended Action 1: School-Based Programs. Schools/districts funded under the SMHI should provide a continuum of prevention and early intervention services including... Linkages to services, either provided on campus or otherwise, through school health centers, county departments of mental health, special education programs, and community-based organizations...*

*Recommended Action 2: Systems and Policy Developments: Programs funded under the SMHI should implement system and policy changes to sustain the school-based programs described above. Changes may include...*

- Development of relationships between school system and county mental health departments to ensure effective referral process of students between systems and effective use of resources to avoid duplication and fill gaps.

- Collaboration with community-based providers that enhance student success, for example health services, tutoring,
CPCA strongly supports the inclusion of these recommended actions in the final Student Mental Health Initiative work plan and would encourage the Board to support an enhanced role for school-based health centers in offering and/or providing referrals to behavioral health services. The partnerships contemplated between school systems and county mental health departments, should also be extended to community-based primary care providers that offer access to behavioral health services. Identifying and publicizing where students can be referred within their community for services beyond what the school system itself can provide will be critical to accomplishing the goals of this initiative.

5. Public Comment Date: 11/3/2010

Submitted by: Marissa Lee

Section Referenced: SMHI, Higher Education, pages 63-65

Name: Marissa Lee

Contact Information: minnalee@ucla.edu

Current Organizational Affiliations: Association of Community Human Service Agencies, California Mental Health Planning Council, California Youth Empowerment Network.

Previous Organizational Affiliations: UCLA undergraduate student (Class of 2008), UCLA Student Health Advisory Committee (2007-08)

Background
My name is Marissa Lee and I am a 24 year old Asian American transition age youth and mental health consumer. I have participated in student health advocacy for the past five years and have worked in public mental health advocacy in Los Angeles County for two-and-a-half years since my graduation from UCLA in 2008. I am the first and only transition age youth to serve on the California Mental Health Planning Council.

I attended the University of California, Los Angeles, as a full time undergraduate student from Fall 2008 to Summer 2010. During my freshman year, I experienced the first onset of mental illness--post-traumatic stress disorder and depression. I struggled with symptoms of mental illness throughout my entire UCLA undergraduate experience.

Although UCLA is a renowned university--known for a fantastic psychology department--the University was poorly equipped to assist me. Before I was able to get the help I needed to manage my symptoms, I behave erratically and struggled academically. I faced barriers in accessing appropriate treatment for my condition, and worse, discrimination from university staff who told me that my condition was my fault. Unlike students with a physical medical condition, I was treated as a disruption and disciplinary problem instead of a student in need.

I stayed at UCLA because I lacked family support and had nowhere else to go. I did not cave into pressure from university staff to leave school because my ability to support myself--and prevent my situation from deteriorating--was completely contingent on my ability to stay in school and graduate. These included:

- **Scholarships**: I had received several scholarships that required full-time student status. I relied on these scholarships not only for tuition but as a living stipend to pay for room and board and medical expenses.

- **Employment**: I held a part time student job at the University to cover my expenses, including the co-pay for my psychologist and other medical expenses including emergency hospitalizations. I would have no income to pay for basic
necessities such as food.

- **Housing**: As a non-student, I would lose dormitory housing and have to find a private apartment opening in the middle of the academic year, when most leases would not be open. I would also lack the funds necessary to pay for a security deposit and movers.

- **Therapy and Medical Insurance**: My medical insurance, which covered the interventions I was receiving, was contingent on full-time student status. (This was before the passage of Michelle's Law, which currently offers some protection to students who require medical leave from their studies.) If I left school I would have no medical insurance and be unable to pay any medical bills, including the cost of therapy.

- **My Future**: UCLA was my one straight shot at recovery and a bachelor's degree. I knew that I had to graduate in order to sustain myself, remain employable, reach recovery, and have a successful future.

As I recovered, I was able to advocate for other students at UCLA and served as an appointed student government position on the Student Health Advisory Committee. As a student in crisis--leveraging whatever campus resources available--and especially during my tenure on the committee, I learned what services are currently available to university students and how to navigate the system.

The feedback I provide below stems from my above experiences. I hope that the programs implemented through the CalMHSA work plan will prevent other students from having to go through what I went through.

**Specific Feedback and Areas of Concern:**

Page 63 - 65 Higher Education (also applies to mirrored segments in Appendix Four)
Suggested Change (in italics): “…activities and suicide prevention. Applicants are strongly encouraged to target unserved and underserved populations with low service penetration rates (eg: Asian American students, LGBTQ students, international students, first generation college students, students with disabilities, and other unserved populations.) Successful applicants…”

**Rationale:** While serving on the UCLA Student Health Advisory Committee I learned that Asian American students are least likely to utilize student counseling/psychological services and that upon intake they exhibit much higher symptoms of distress due to delaying seeking treatment. Asian American students face cultural stigmas against mental illness and are also expected to meet a model minority stereotype.

Studies have found that Asian American college students are more likely to think about and attempt suicide than white students. Young Asian-Americans, between 18 and 34, have the highest estimates of thinking about, planning, and attempting suicide of any age group. Depression is the second leading cause of death for Asian American women, especially college aged women.

There are more Asian Pacific American (a very broad and diverse group) students than white students in the University of California. Given the majority of students in the University of California system are from the Asian Pacific American population, it is imperative that any RFP or project take the aforementioned factors into consideration. Other populations that have higher rates of stress or mental health risk should also be targeted as they are currently not being reached by existing services.

**Suggested Change:** “The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health, wellness on college campuses, and an understanding of the legal disability rights of students with

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4 “Lifetime Suicidal Ideation and Suicide Attempts in Asian Americans” *Asian American Journal of Psychology*, March 2010
5 “Correlates of Suicidal Behaviors Among Asian Americans” *Archives of Suicide Research*, Jun. 2009
6 “Asian American women and Depression Fact Sheet” *National Alliance on Mental Illness*
mental illness.”

**Rationale:** When I was a student at UCLA I faced discrimination for my mental illness. Beyond stigma and a lack of understanding, my privacy and legal rights were threatened to the point where I felt I had no choice but to retain a lawyer from Student Legal Services to defend me.

Students with mental illness may never know that they have access to several legal protections. In addition to education about mental health and stigma, administrators, faculty, staff, and student leaders should receive training on topics such as:

- Reasonable accommodation
- Americans with Disabilities Act
- Michelle’s Law
- HIPAA, student medical confidentiality, and disclosure

This training would protect students from discrimination from faculty and the administration, educate staff about reasonable accommodations, and protect the institution from liability.

**Suggested Change:** “These activities would focus on mutual support, student retention, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, sexual assault and acquaintance rape, homesickness, academic performance, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.
Rationale: While the last thing that a student experiencing onset of mental illness should have to worry about is maintaining a passing grade point average, the reality is that many students have no choice but to remain a student. And obviously, the students who would benefit most from CalMHSA would not be able to access PEI Services if they fail out of college.

Students should be supported academically so they are not forced to drop out due to their mental health status. Students should be connected and registered with the administration’s services for students with disabilities. Student retention services could include:

- Academic counseling and advising
- Tutoring
- Note taking
- Exemptions or accommodations
- Supportive services
- Contacts between counseling staff and faculty

Retention services would prevent students from losing major supports such as access to their existing clinician (often employed by the school), scholarships, insurance coverage, housing, and career services. Access to these services is contingent on maintaining student status.

I was shocked to see that “student retention” was not included in the work plan summary as a practical necessity and absolute
priority. Academic failure is a major obstacle to recovery.

I have recommended that “sexual assault” be included as an example program because many students I met with mental illness had been sexually assaulted while as a student at UCLA. These students would not seek mental health services due to fear and stigma. At least 1 in 4 college women will be the victim of a sexual assault during her academic career.7

The work plan seeks to "promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community." Training, suicide prevention, and peer support services should not overlook the high incidence of acquaintance rape and sexual assault on California college campuses.

Appendix 5 E.

The UCSMHC is comprised of UC students and administrators and is tasked with developing student mental health policy for the UC system; their perspective would have been invaluable in the development of the higher education segment of the Student Mental Health work plan.

I was surprised to see that stakeholder input was not sought from the University of California Student Mental Health Committee or any other entity or individual—particularly students--stated as affiliated with the University of California system.

6. Public Comment Date: 11/3/2010

Submitted by: California Mental Health Planning Council

7 “Statistics about Sexual Assault and College Campuses” Sarah Lawrence College
<table>
<thead>
<tr>
<th>Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
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<tbody>
<tr>
<td>Section Referenced: Suicide Prevention, page 34, Recommended Action 3.11, Stigma and Discrimination Reduction, Page 50, 54, Recommended Actions 1.5, 2.4, SMHI, page 64, page A4.5 Training &amp; Peer-to-Peer</td>
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<tr>
<td>November 3, 2010</td>
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<tr>
<td>CalMHSA</td>
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<tr>
<td>Attn: Laura Li</td>
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<tr>
<td>George Hills Company</td>
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<tr>
<td>3043 Gold Canal Drive, Suite 200</td>
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<tr>
<td>Rancho Cordova, CA 95670-6394</td>
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<tr>
<td>Re: CMHPC Comments on the California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan</td>
</tr>
<tr>
<td>The California Mental Health Planning Council (CMHPC) is mandated in federal and state statute to advocate for children and youth with serious emotional disturbances and for adults and older adults with serious mental illness and to provide oversight of the public mental health system.</td>
</tr>
<tr>
<td>The comments below were gathered by the Children and Youth Subcommittee (CYSOC) and the Transition Age Youth Subcommittee (TAY). These comments and suggested changes reflect members’ insights on the needs of children and TAY within the mental health system. The CMHPC would like to thank CalMHSA for this opportunity to provide feedback to the CalMHSA Statewide Prevention and Early Intervention Implementation Work Plan.</td>
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## Suicide Prevention

**Recommended Action 3.11**

Incorporate and build capacity for peer support and peer-operated services models, such as peer warm lines and peer-run crisis respite centers, as a part of suicide prevention and follow-up services.

- The CMHPC would like to stress the importance of 3.11. Peer support and peer-operated services models are an essential tool in suicide prevention.

## Stigma and Discrimination

**Recommended Action: 1.5**

Recognize peer run and peer led programs as an important means for reducing stigma.

(Page 50)

Work with racial and ethnic community groups to ensure cultural relevance and to eliminate stigmatizing barriers.

- **Suggested addition:** “Work with consumers from the target population to ensure age and generational relevance.”

Page A2.11
Recommended Action 2.4

Create a more holistic and integrated approach to physical health and mental wellness by promoting integrative delivery models of mental health, primary health care, and social services; achieving parity between medical and mental health services in terms of coverage and financing; and utilizing spirituality and faith-based practices as tools for wellness and recovery.

(Page 54)

Train providers on the value of spirituality in the wellness and recovery process

- **Suggested Change:** “Train providers on the value of spirituality and cultural competence in the wellness and recovery process.”
- **Rationale:** The CMHPC would like to stress the importance of cultural competency when training providers.

**Student Mental Health Initiative**

Page 64

**Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention**

These systems shall design and administer programs that will focus on three key strategic directions: training, peer support activities and suicide prevention. Successful applicants will demonstrate need and will emphasize culturally relevant and appropriate approaches, linkages to local community MHSA Prevention and Early Intervention plans and/or Community Services and Supports plans, and collaboration with mental health and substance abuse prevention partners.

- **Suggested Change:** “...activities and suicide prevention. Applicants are strongly encouraged to target underserved populations with low service penetration rates (e.g.: Asian American students, LGBTQ students,
international students, first generation college students, students with disabilities, and other unserved populations.) Successful applicants…”

- **Rationale:** The CMHPC believes it is important that special attention be paid to these currently underserved and unserved student populations

Page A4.5

**Recommended Action SMH 1**

**Training:** The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health and wellness on college campuses. The training would be designed to improve recognition and responses to students experiencing mental distress, to reduce stigma and discrimination against persons who become identified with mental illness, and to promote a campus environment that enhances student success providing hope, supporting resiliency, and creating a healthy learning community.

- **Suggested Change:** “The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health, **wellness on college campuses, and the disability and legal rights of students with mental illness.**”

- **Rationale:** Administrators, faculty, staff, and students should receive training increase their awareness of the disability and legal rights of students with mental illness (including reasonable accommodations under the Americans with Disabilities Act). This training would protect students from discrimination from faculty and the administration, educate staff about reasonable accommodations, and protect the institution from liability.
Peer-to-Peer Support: These activities would focus on mutual support, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.

- **Suggested Change:** “These activities would focus on mutual support, student retention, promoting acceptance of cultural diversity, disability, empowerment strategies, and reduction of the stigma associated with mental illness. Peer-to-peer services instill hope while teaching successful coping strategies and relaying information about how to navigate health and mental health systems. Such programs could also effectively address issues of trauma, loss, identity, relationships, homesickness, academic performance, and achievement pressure and would provide mental health and emotional support that are defined useful by students themselves.

- **Rationale:** The CMHPC recommends that SMH 2 also focus on “student retention” services such as academic counseling and advising, tutoring, note taking, course exemptions and other supportive service. Students should be supported academically so they are not forced to drop out due to their mental health status. They will not be able to access these PEI Services if they fail out of college. Academic failure is a major obstacle to recovery. Retention services would prevent students from losing major supports such as access to their existing clinician, scholarships, insurance coverage, housing, and career services are often contingent on academic status.
The CMHPC would also like to endorse the comments submitted by the California Youth Empowerment Network (CAYEN) regarding the CalMHSA Implementation Plan.

7. Public Comment Date: 11/4/2010

Submitted by: Phillip R. Crandall, Director, Humboldt County Department of Health and Human Services

Section Referenced:

From: Crandall, Phillip [mailto:PCrandall@co.humboldt.ca.us]
Sent: Thursday, November 04, 2010 5:38 AM
To: Laura Li
Cc: LaHaie, Barbara
Subject: CalMHSA Work Plan for State Prevention and Early Intervention

Humboldt County Department of Health and Human Services has the following recommendations in relation to the work plan:

1. Specify TAY and TAFY as target populations to be engaged;
2. Establish methods of inclusion of CAYEN members in the planning and implementation of activities;
3. Establish methods of melding peer support and evidenced based practice as a core outreach and engagement strategy for TAY and TAFY populations;
4. Utilize TAY serving county and state organizations to assist in developing effective marketing, training and inclusionary activities.

Phillip R. Crandall, Director
Humboldt County Department of Health and Human Services
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

8. Public Comment Date: 11/4/2010

Submitted by: Betsy Sheldon, State of California Community Colleges Chancellor’s Office

Section Referenced: Pages 7, 11, 18, 31, 32, 33, 39, 63-65, Appendix 2, pages A2.1 and 1.24, Appendix 2 pages A2.24 and A2.25

November 4, 2010

CalMHSA
Laura Li
George Hills Company
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA

Attention: Laura Li

Thank you for the opportunity to provide public comment on the California Mental Health Services Authority Statewide Prevention and Early Implementation Work Plan. My comments are provided below.

1. I am requesting a response to previously submitted questions/comments/or recommendations to which I have not yet received a response or that have not been addressed in this version of the Plan. These are as follows:

   o Clarification/explanation of funding decreases. In the September 27 version, the amounts listed for Student Mental Health are $24.6 M (Draft Implementation Plan, 9/27/10, Section C, page 43). At the 10/14/10 Board meeting, I requested explanation during public comment about the decrease to 22.5 (Implementation Plan, page A1.1). During the 10/18/10 call, a verbal explanation was provided by Cal MHSA staff and Cal MHSA also offered
to provide a written explanation. To date, this has not been received so I am requesting it be provided through this public comment process. It appears that the funding decreases are due to the need to include costs for planning, indirect admin expenses for the JPA, and operating reserve (as described in the Budget Narrative, pages A1.2-A1.8). Please confirm or clarify if this is not the case.

- **Page 7 and page 11.** Request again that this section be modified with language previously submitted to accurately reflect the processes used to develop the Stigma and Discrimination and Suicide SPs were more extensive and robust than the SMHI process. Again, my main issue is that the SMHI process included basically two meetings that were convened over a two month period which occurred during the summer of 2007, a time that is difficult for both K-12 and higher education stakeholders to participate given that schools/campuses are not in session. The intent of requesting this be acknowledged is not to diminish the input that was received by stakeholders, or to suggest we revisit the process, but merely to request an accurate historical perspective.

- **Page 33 and page 39:** (page 23 of last version). Suggested edits/ recommendations still not made from original suggestion submitted on 10/4/10. Suggested language included again and attached as a PDF with wording included.

2. **New Comments:**

- **Pages 18, 31, 32:** Recommend consistency in use of word/term gatekeeper or include a list of definitions so that when the RFPs are written, it is clear what the intent is. For example, on page 18, the term “Community gatekeepers” is used; on page 31, evidence-based population specific gatekeeper training is mentioned; on page
32, community is used again. Faculty and staff at higher education systems (and teachers and school staff for K-12) are also important gatekeepers so it is important that terms and language for the Plan is inclusive and clear as possible.

- Page 63-65: Nice, looks good!

- Appendix 2, page A2.1. Recommend that program deliverables, bullet 2 be more expansive – at minimum, include K-12 and higher education among the partners listed.

Page 1.24: Goal 1: increase the number of school and campus based.

- Appendix 2: Goals on page A2.24 do not seem correct for higher education – the language is the same for K-12 on page A2.25. I have not seen goals in other documents so don’t have language to compare but this does not seem correct. Recommend this be revised to better reflect higher education (i.e., discipline referrals mean something different at schools than colleges.)

Please contact me if you have questions or need additional information. I look forward to continuing to partner with Cal MHSA to implement these needed projects for our campuses, students, and communities.

Sincerely,

Betsy Sheldon
Specialist
Student Services and Special Programs
bsheldon@cccco.edu
(916) 322-4004
The purpose of the Statewide Information and Dissemination Campaign Suicide Prevention Education Program (SPEP) is to provide family, peer, and consumer education through evidence-based Gatekeeper training models, and to incorporate and build capacity for peer support and peer support service models.

Cultural and personal beliefs about suicide and mental illness, concerns about stigma and discrimination, and feelings of hopelessness can dissuade people from seeking help. There is a need for education about the warning signs of suicide with a clear and consistent message about how to respond to suicide behaviors. Strategies that include population-specific risk factors and promote help-seeking behavior encourage people to reach out to family, friends, resources in their communities, and community gatekeepers. Gatekeepers are defined as those who regularly come in contact with individuals who may be contemplating suicide. Gatekeeper models provide education and training in identifying the warning signs of mental health problems and suicide risk. The gatekeeper model is an effective strategy for reaching high-risk individuals who may not otherwise seek mental health services or whose risk factors may not be visible to health and mental health professionals. Gatekeeper training targets a broad range of people in the community, for example: School health personnel, employers and supervisors, faith-based community leaders, natural community helpers (such as promotoras, traditional healers), hospice and nursing home staff, senior center staff, group home personnel, and emergency health care personnel, including first responders.

This program shall fund providers who:

- Identify and implement population-specific strategies that promote suicide prevention through help-seeking behavior, and educate family, friends and community members about the warning signs of mental health problems and suicide risk.
- Identify and implement evidence-based gatekeeper training models.
- Conduct regional train-the-trainer gatekeeper training.
- Develop a “how to” manual for sustaining survivor support groups locally, including information about funding, training, 501c3 status, and sustainability.
- Incorporate and build capacity for peer support and peer-operated services models (for example peer-run crisis respite centers), as part of suicide prevention and follow-up services.
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

9. Public Comment Date: 11/05/2010

Submitted by: Older Adult System of Care Committee of the California Mental Health Planning Council

Section Referenced: Pages 12, 13, 17, 18, 20, 29, 30, 33, 34, 38, 48, 49 and 50

November 5, 2010

To: CalMHSA

From: Older Adult System of Care Committee/CMHPC

Subject: Work Plan Comments

The California Mental Health Planning Council is mandated by federal and state statute to advocate for children with serious emotional disturbances and adults and older adults with serious mental illness, to provide oversight and accountability for the public mental health system, to advise the Administration and the Legislature on priority issues, and to participate in statewide planning. With passage of the Mental Health Services Act, the Planning Council also has responsibilities related to workforce development.

One of the systems of care committees that make up the California Mental Health Planning Council is the Older Adult System of Care Committee (OASOC). On November 1, 2010 the OASOC convened a conference call to discuss the California Mental Health Services Authority Statewide Prevention and Early Intervention Implementation Work Plan. Contained below are the results of that effort and the changes suggested.

As an overarching recommendation, the Planning Council’s Older Adult System of Care Committee wants to ensure that the implementation of all deliverables in the Work Plan target age groups across the lifespan (children/youth, transition age youth,
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

... and include racially, ethnically and culturally diverse populations. This recommendation supports the following two “Principles and Policy Directions” identified in the CalMHSA Implementation Work Plan on page 4: 1) “All initiatives should have a life span appropriate focus for children, transition age youth, adults and older adults” and 2) “All initiatives should be culturally and linguistically competent, respectful and inclusive of California’s diverse population.”

In addition to this overall recommendation, the OASOC Committee has indicated specific places in the Work Plan where age- and diversity-specific language should be inserted. We are using “life span” and “age span” interchangeably.

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<tr>
<th>Page</th>
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<tbody>
<tr>
<td>12</td>
<td>Sentence Below Outcomes, Suicide Prevention</td>
<td>Change first sentence to read – “Reduced Suicide Rates in California Across the Age Spans resulting in a 5% Reduction in Suicide Rates the First Year…” Next sentence change to read – “…Activities for Consumers who are At-Risk for Suicidal Behaviors Across the Age Span (Life Span).” Further down same page change- “Improved Availability, Accessibility, and Quality of Services for those Historically Underserved Racial, Ethnic, and Cultural Groups Across the Age Span with High Suicide Rates.”</td>
</tr>
</tbody>
</table>
| 13 | Second Bullet from the Bottom | Add to sentence so that it reads –
“...indicated that suicide risk is high (e.g. onset of a mental illness particularly depression and after a hospital discharge). |
| 17 | Last Paragraph Above - Recommended Action | Add to sentence so that it reads –
“...indicated that suicide risk is high (e.g. onset of mental illness particularly depression and immediately after a hospital discharge). |
| 18 | Second Bullet from the Bottom | Add to sentence so that it reads –
“...assistance to local Suicide Prevention Lines, develop culturally and age specific suicide prevention training ...” |
| 18 | First Bullet from the Bottom | Add to sentence so that it reads –
“... will be established and convened to address age and culturally specific roles in preventing...” |
| 20 | First Paragraph | Add to sentence so that it reads –
“A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic, and cultural groups across the age spans that have been historically underserved.” |
## Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

| 20 | The Second Paragraph First Bullet Under Program Deliverables | Insert information from the second paragraph into the first bullet under Program Deliverables as follows: –

“Teach suicide risk and “recognize and intervene” strategies and skills in a variety of personnel systems and community environments such as health clinics (e.g., primary care and prenatal care), older adult service providers, mental health centers, emergency response systems, crisis centers, alcohol and drug programs, etc. .” |

| 29 | First Paragraph Under Program Description | Add to sentence so that it reads –

“…to communities to educate and raise awareness about suicide risks and prevention, and mental health **across the lifespan including diverse populations.**” |

| 30 | Third Bullet from the Bottom | Add to sentence so that it reads –

“…educate and raise awareness about suicide risks and prevention, and mental health **across the lifespan including diverse populations.**” |
| 33 | Third Paragraph Down | Remove the word *regularly* from the first sentence so that it reads –  
“Gatekeepers are defined as those who come in contact with individuals...” |
| 34 | First Bullet Under Deliverables | Add to sentence so that it reads –  
“...evidence based population-specific *(by age, race, culture, ethnicity, and gender)* gatekeeper training models that identify and implement population-specific *by age, race, culture, ethnicity, and gender* strategies and promote...” |
| 34 | Second Bullet | Add to sentence so that it reads-  
“Conduct regional train-the-trainer gatekeeper training *that includes age, race, culture, ethnicity, and gender specific strategies.*” |
| 38 | Third Bullet | Add to sentence so that it reads-  
“Convene expert workgroups and convene expert panels *who understand issues across the age span and within racially, ethnically and culturally diverse communities.*” |
## Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

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<tr>
<td><strong>48</strong></td>
<td><strong>SDR 1.6</strong></td>
<td><strong>It is felt that this entire Recommended Action item should be written into the Program Description as well as the Deliverables. This identification of recognizable stigmas should be carried throughout the document, not in just one place.</strong></td>
</tr>
</tbody>
</table>
| **49** | **Second Bullet** | **Add to sentence so that it reads:**
> “Develop messages and relevant materials for the public that explain mental health challenges and promote social inclusion **across the lifespan with cultural and age specific emphasis.**” |
| **50** | **First Sentence** | **Change and add to sentence so that it reads:**
> “Program intervention **may (delete) will implement as many as possible utilizing a lifespan approach:**” |
| **50** | **Third Bullet** | **Add to sentence so that it reads:**
> “…and forums that feature peers **from across the lifespan** who are successfully dealing with…” |
| **50** | **Second Sentence** | **Add to sentence so that it reads:**
> “Applicants may address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination **based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases**, with efforts” |
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

| Section Referenced: | SDR 1.6 |

We applaud the work undertaken by CalMHSA and appreciate the opportunity to comment on the Work Plan. It is hoped that the comments we have suggested will be considered and used to benefit the Older Adults of California.

If you have any questions or concerns, please contact Michael Gardner at 916-651-3819 or email him at:

Michael.Gardner@DMH.CA.Gov

Sincerely,

Stephanie Thal, MFT
Chair Older Adult System of Care
California Mental Health Planning Council

10. Public Comment Date: 11/05/2010

Submitted by: Latino Coalition for a Healthy California

Section Referenced:
November 3, 2010

CalMHSA
Attn: Laura Li
George Hills Company
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670-6394

Re: Comments on the California Mental Health Services Authority
Statewide Prevention and Early Intervention Implementation Work Plan

The vision of the Latino Coalition for a Healthy California (LCHC) is for a California where Latinos can live healthier lives as a result of improved social, economic, and environmental factors. As the leading voice for Latino health, representing over 2300 members and community partners in four regional networks of the state, we have conducted informational briefings on mental health for three consecutive years in the State Capitol.

We would like to add our voice to the written comments submitted by the California Primary Care Association, in particular the points made in the enclosed pages. LCHC thanks CalMHSA for the opportunity to comment and commends the Board for including strategies and actions that foster the critical integration of primary health care and mental health services.

Please do not hesitate to contact us with any questions or concerns.

Sincerely yours,

Chad Silva
Statewide Policy Analyst
### Stigma & Discrimination Reduction

On page 45, after the first sentence under B. “Below are the CalMHSA Statewide PEI Summary of Stigma and Discrimination Reduction with “recommended actions” identified by priorities, themes, and actions.”

Add the following:

A set of “Core Principles” were at the forefront of the original “California Strategic Plan on Reducing Mental Health Stigma and Discrimination”. Several of these should be noted and incorporated when addressing all the recommended actions:

- Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.
- Employ a life-span approach to effectively meet the needs of different age groups.
- Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experience mental health challenges comes from voluntary programs that offer choice and options.

[Taken from page 43 of that original report. Some core principles were omitted from our recommendation because they might be confusing in regards to this work plan.]
Submission 2

On page 48, under “Program Description” add between the 4th and 5th paragraphs (after the sentence, “Discrimination is manifested when individuals are deprived of housing, educational, employment, and so many other opportunities, based on mental, social, emotional, and/or other behavioral impairments”)

Add the following paragraph:

Many individuals, families, and communities experience the burden of multiple stigmas and discrimination based on race, ethnicity, and other factors that affect their ability to access and receive appropriate mental health services. This prejudice and discrimination is stressful and also affects physical and mental health. Despite experiencing multiple stigmas, some racial and ethnic communities may have certain culturally protective factors that can help counter stigma and the stresses of mental health conditions.

[The above information was taken directly from the original Strategic Plan on Reducing Mental Health Stigma and Discrimination, pages 17-18.]

Submission 3

On page 50, after the last bullet “Work with racial and ethnic communities groups to ensure cultural relevance and to eliminate stigmatizing barriers.”

Add the following bullet:

- Work with racial and ethnic community groups to identify and strengthen culturally protective factors that can help counter stigma and the stresses of mental health conditions.
Submission 4

Appendix 2 (2\textsuperscript{nd} version), Page A2.15, after “Section B. CalMHSA California Plan on Stigma and Discrimination Reduction” and before “Priority One:.....”

Add the following:

A set of “Core Principles” were at the forefront of the original “\textit{California Strategic Plan on Reducing Mental Health Stigma and Discrimination}”. Several of these should be noted and incorporated when addressing all the priorities and recommended actions:

- Implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations.
- Employ a life-span approach to effectively meet the needs of different age groups.
- Recognize that individuals experiencing mental health challenges are resilient and have the capacity for recovery, and that the best results in treatment for those experience mental health challenges comes from voluntary programs that offer choice and options.

[Taken from page 43 of that original report. Some core principles were omitted from our recommendation because they might be confusing in regards to this work plan.]
Submission 5

In the revised Appendix 2, on Page A2.16 under “Program Deliverables”, the first bullet, add the underlined words:

- Form a statewide collaborative of local coalitions of diverse representatives, including those with mental health challenges, their families, individuals knowledgeable about serving underserved cultural communities in the area, and representatives across the age span.

- Develop electronic and print materials for the general public including materials in at least threshold languages (other than English) for the area.

- Rely on mental health consumers and family members, including those from underserved cultural communities, to raise awareness of the importance of mental health across the lifespan.

- Develop electronic and print media to counter stigma and discrimination including materials in at least threshold languages (other than English) for the area.

Section on Student Mental Health

Language to add:

Page 64 of the Plan under Recommended Actions, and the sub area of Training:

- Individuals who are bilingual and ethnically diverse, and who identify as LGBTI should be trained. The training should have a component on cultural sensitivity so that trainees will be better able to identify and assess for stressors that can impact the mental health of students in higher education.
<table>
<thead>
<tr>
<th>Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</th>
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<tr>
<td>Page 64 of the Plan under Recommended Actions, and the sub area of Peer to Peer Support:</td>
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<tr>
<td>- Peers with experience accessing mental health services would be beneficial. Peers who are ethnically or culturally diverse or who identify as LGBTI may provide effective support to students who are diverse.</td>
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<tr>
<td>Page 67 of the Plan under The Statewide K-12 Program Responsibility for statewide systems and policy development:</td>
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<tr>
<td>- ...key mental health provider agencies who serve individuals who are ethnically and culturally diverse individuals, or who identify as LGBTI.</td>
</tr>
<tr>
<td>Page 68 of the Plan under The Regional K-12 Program: Responsibility for school-based programs, technical assistance, and education and training across regional programs</td>
</tr>
<tr>
<td>- (paragraph 1) Training should include how discrimination or bias toward ethnically and culturally diverse students or students who identify as LGBTI can result in injurious and harmful consequences.</td>
</tr>
<tr>
<td>Page 69 under #1 School-Based Programs: School districts funded under the SMHI should provide a continuum of prevention and early intervention services including:</td>
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<tr>
<td>- (4th paragraph) Linkages should include community-based organizations who serve ethnically and culturally diverse, and LGBTI individuals.</td>
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**In Revised Appendix 2**

Page A2.24
After the first bullet under Program Deliverables (after “Mental health and wellness training for students, faculty, staff and administrators) add:

- Individuals who are bilingual and ethnically diverse, and who identify as LGBTI should be trained. The training should have a component on cultural sensitivity so that trainees will be better able to identify and assess for stressors that can impact the mental health of students in higher education.

In the second bullet (becoming the third if above language is accepted), add a second sentence after “Peer-to-peer support activities...associated with mental illness”. Peers with experience accessing mental health services would be beneficial. Peers who are ethnically or culturally diverse or who identify as LGBTI may provide effective support to students who are diverse.

On page A2.25 under “Program Deliverables”, to the first bullet add:

- “A statewide advisory body that convenes and staffs a “Student Mental Health Policy Workgroup that includes key mental health provider agencies who serve individuals who are ethnically and culturally diverse individuals, or who identify as LGBTI.

Then add an additional bullet:

- Training should include how discrimination or bias toward ethnically and culturally diverse students or students who identify as LGBTI can result in injurious and harmful consequences.

Then add under “Use of appropriate youth peer-to-peer.....”

Linkages should include community-based organizations who serve ethnically and culturally diverse, and LGBTI individuals.
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<th>Public Comment Date: 11/05/2010</th>
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<tr>
<td></td>
<td>Submitted by: Solano County</td>
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<td></td>
<td>Section Referenced: Page 67</td>
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<td>Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</td>
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<td>November 5, 2010</td>
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<td>CalMHSA</td>
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<tr>
<td>Attn: Laura Li</td>
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<tr>
<td>George Hills Company</td>
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<tr>
<td>3043 Gold Canal Drive, Suite 200</td>
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<tr>
<td>Rancho Cordova, CA 95670-6394</td>
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<tr>
<td>RE: Comments on the CalMHSA Prevention and Early Intervention Implementation Work Plan</td>
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<tr>
<td>Dear CalMHSA:</td>
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<tr>
<td>Solano County is pleased to see implementation of the Prevention and Early Intervention Statewide Projects moving forward to allow for prompt and meaningful projects that support the statewide initiatives of Suicide Prevention, Stigma and Discrimination Reduction, and Student Mental Health.</td>
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<tr>
<td>The CalMHSA Implementation Work Plan states that a complex process was used for prioritization of Recommended Actions, including reviewing the Strategic Plans, taking into account stakeholder input, and Principles and Policy Direction from the MHSOAC. In this process, Solano County Mental Health is disappointed that the majority of Recommended Actions that were priorities the MHSA Stakeholders in Solano County were not chosen as priorities for CalMHSA implementation. We recommend that information is added to the work plan about how Recommended Actions that were not chosen as priorities will be addressed or overlap with other Recommended Actions which are priorities. This would assist Stakeholders in recognizing how their voices have been taken into consideration when priorities were chosen and how their needs will be met around PEI Statewide Projects.</td>
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<tr>
<td>In addition, Solano County is not represented on the County Superintendent Regions on Page 67. Solano County is in Region 4 and should be listed as such.</td>
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<tr>
<td>Solano County Mental Health looks forward to continuing a fruitful partnership with CalMHSA. Should you have questions, please contact me at 707-784-8320. Thank you for your consideration.</td>
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<td>Sincerely,</td>
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<td>Gena Lingenfelter</td>
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<td>Interim, Mental Health Deputy Director</td>
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<td>cc: CalMHSA File FY 2010-11</td>
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<td>13.</td>
<td><strong>Public Comment Date:</strong> 11/06/2010</td>
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<td></td>
<td><strong>Submitted by:</strong> NAMI California</td>
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<tr>
<td></td>
<td><strong>Section Referenced:</strong> Pages 1-10, 11-44, 21-24, 28-31, 45-60, 45-52, 61-71, and 64</td>
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<td></td>
<td>November 6, 2010</td>
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<td></td>
<td>Via email to <a href="mailto:laura.li@georgehills.com">laura.li@georgehills.com</a></td>
</tr>
</tbody>
</table>
|     | CalMHSA  
     | George Hills Company  
     | 3043 Gold Canal Drive, Suite 200  
     | Rancho Cordova, CA 95670-6394  
     | Attn: Laura Li |
|     | Re: NAMI California Comments on the California Mental Health Services Authority |
|     | Statewide PEI Implementation Work Plan dated October 7, 2010 |
|     | Dear Ms. Li, |
|     | NAMI California appreciates the opportunity to comment on CalMHSA’s October 7, 2010 Draft Work Plan for PEI Statewide Programs. NAMI California is the state organization of the National Alliance on Mental Illness (NAMI). Our state organization includes 72 affiliates representing over 22,000 members statewide. NAMI California members represent families, friends and individuals from all walks of life whose efforts serve to strengthen communities across our state. From its inception in 1979, NAMI has been dedicated to improving the lives of individuals and families affected by mental illness through education,
advocacy and support. The education of consumers and family members, providers, community partners, and the general public is central to our advocacy. In addition, it is our aim to reach out to people of all ages, cultures, ethnicities, and orientations who have been served, unserved, or inappropriately served by the mental health system. We seek to ensure that our communities not only to recognize that it is possible for individuals to successfully recover from episodes of serious mental illness, but to thrive. We further emphasize that individuals and family members with lived experience bring valuable perspectives and leadership to mental health, including creative and sustainable ideas for successful program implementation.

NAMI’s community education and support programs have been growing for many years. At the heart of these programs, and the creation of future programs, are principles that emphasize the values and of lived experience and the benefits that result when these values are incorporated into consumer, family, and community support and education. These principles inform the questions, comments, and recommendations that follow regarding CalMHSA’s Draft Work Plan.

Priorities Framing NAMI California’s Recommendations

- Emphasis on formalizing collaboration of CalMHSA with statewide consumer and family member organizations and other diverse statewide community partners
- Emphasis on leveraging and supporting existing resources that can be provided by organizations and other entities emphasizing the perspective of lived experience
- Emphasis on addressing unmet service needs through capacity building projects
General Comments on Structure of Implementation and Stakeholder Process

(Introductory Sections of Work Plan)

*pp. 1-10*

Need For Continued Development of Stakeholder Engagement Process

NAMI California recognizes that CalMHSA membership is organized around its foundation as a Joint Powers Authority, a mechanism for counties to pool their MHSA funds allocated to Statewide Prevention and Early Intervention in order to maximize resources and ensure optimum outcomes statewide. NAMI California appreciates the fact that CalMHSA continues to grow in membership and, as a result, administrative and program policies have been evolving. As a statewide community stakeholder in this process, NAMI California appreciates CalMHSA’s efforts to adapt certain procedures of stakeholder engagement to the needs of statewide community representatives. In addition, we acknowledge two factors that have necessitated the need for CalMHSA’s procedures for stakeholder engagement to continually evolve: The PEI Statewide Guidelines do not contain extensive detail outlining the stakeholder process; CalMHSA is now a partner in the Mental Health Services Act, which is governed by core values (some of which are referenced in CalMHSA’s Work Plan on *Page 2*). Two of the central values represent that programs and services are to be client and family member driven and that they need to be delivered in a culturally competent manner and be focused on reducing disparities among cultural and ethnic groups who have a history of being unserved, underserved and inappropriately served.

Page 2

NAMI California recommends that the language around MHSA values be strengthened on this page. Re: “*Cal MHSA’s vision is to promote systems and services arising from community mental health initiatives and to respect the values of the California Mental Health Services Act.*” - The word *respect* should take on a more active connotation and be changed to *implement.*
In order to put these core values into practice, there should be designated decision-making roles for statewide community stakeholders or formal advisory roles to the CalMHSA Board of Directors. Currently, the CalMHSA board does not include members whose sole purpose is to represent clients, family members, and diverse community stakeholders, nor has the board formally expressed a desire to include such membership. To date, the CalMHSA board is composed solely of county governmental representatives who must fulfill the role and responsibilities of their county agencies, governing elected officials, and county and state mandates. NAMI California respectfully requests that CalMHSA expand its formal structure to CalMHSA include statewide community stakeholders representing clients, family members and representatives from underserved racial, ethnic, and cultural communities across the lifespan.

“CalMHSA stakeholders requested additional accommodations for more focused input. The Ad Hoc Committee readjusted some of the timelines in response to this request.”

As this is the first mention of an Ad Hoc Committee in this document, it is important to have previously defined this committee, its membership and its function. It is also important to give the full name of the committee and specify, if necessary, the reason for the term “Ad Hoc,” if this has implications in terms of its function or its responsibilities with regard to public information.

Multiple references to stakeholders – pps. 1-10

It is important to note that the statewide community stakeholders who are currently most engaged in CalMHSA’s processes (i.e., those who have been participating in the last few CalMHSA Board Meetings and Ad Hoc Implementation Committee Calls) have been drawn in primarily by their own interest and desire for inclusion. This participation has required tenacity and has not been the direct result of active outreach on the part of CalMHSA. Some community stakeholders, including NAMI California, are attempting to cultivate a more collaborative relationship with CalMHSA and are continuing to communicate with CalMHSA about ways to accommodate more effective participation. NAMI California recommends that in developing and refining policies for
engagement, CalMHSA continue to expand active outreach to stakeholders across the state. Since CalMHSA will be hosting focus groups in December, for example, it will be important to bring in as many diverse perspectives as possible.

Page 4

“Stakeholders have been provided an active role throughout the process of the development of the draft work plan.”

NAMI California appreciates continuing attempts by CalMHSA to accommodate stakeholder requests. At the same time, we recognize that since stakeholders do not have a formal role within the structure of CalMHSA (as referenced above) the current involvement and/or limitations of the current role of stakeholders should be more thoroughly described at this point in the Work Plan.

NAMI California appreciates that CalMHSA has included an entire tab section on its website for Stakeholders. However, neither the general category of community stakeholders nor the specific category of clients and family members is listed on the “Strategic Partners” page on CalMHSA’s website. Although this is not a direct comment on CalMHSA’s Work Plan, we recommend that it is important to acknowledge partnership with community stakeholders by including this reference on your “Strategic Partners” page. CalMHSA November 6, 2010 Page 4

CalMHSA Membership Expansion and Statewide Effect

Page 4

Since not all Counties have joined CalMHSA, the Plan will implement eighty-five percent of the available resources. This text does not clarify how CalMHSA intends to plan for implementation of these statewide programs in light of the fact that not all funds are available to them and not all counties are yet participating. More detail should be provided as to how CalMHSA envisions the plan for achieving a statewide effect considering these limitations.
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

Principles and Policy Directions for Implementation

Page 5

- “Available resources will limit the scale of implementation.”

Though the above comment makes realistic sense, it does not appear to be a guiding principle/policy direction provided by the MHSOAC in its Guidelines for PEI Statewide Programs. There may be a better place to state this than under a heading pertaining specifically to content found in the MHSOAC Guidelines. In the PEI Statewide Guidelines, the only directions that appear to refer to limits in funding are that funds are to be used for statewide PEI planning, evaluation and administration and that funds are to be used proportionally as dictated for the three programs.

Suicide Prevention

pp. 11-44

NAMI California asserts that it is essential for CalMHSA to work closely with the California Department of Mental Health’s Office of Suicide Prevention to integrate new implementation efforts with work currently being done across the state. This will help to avoid duplication of efforts and to ensure that capacity building across our state takes place on a uniform and immediate basis.

No linkage in text

Note on Recommended Action SP 1.1 – Establish Office of Suicide Prevention.

Although the Office of Suicide Prevention has already been created by State DMH and is not included in this Work Plan, SP 1.1 - Establish Office of Suicide Prevention – should be mentioned somewhere in this Work Plan with regard to what coordination will take place between State DMH and CalMHSA. This has been a comment by stakeholders in Ad Hoc Implementation Committee meetings, as well as a need indicated by State DMH. CalMHSA
Recommended Action SP 1.3 - Develop a network of public and private organizations to develop and implement strategies to prevent suicide.

As this is a high priority reportedly recommended by 5 statewide and 2 county organizations, NAMI California recommends that this be linked with SP 1.2, which is not included in this Work Plan, but was reported as being prioritized by 4 statewide and 5 county organizations. Recommended Action 1.2 is about integrating, coordinating, enhancing & improving policies. These steps are necessary in order to refine existing strategies and avoid duplication of efforts prior to development and implementation of additional strategies.

Recommended Action SP 1.5 and SP 1.6 - Expand the number and capacity of accredited suicide prevention hotlines based in California by assisting with the accreditation process at the local level. Enact policies that make establishing and maintaining suicide prevention accreditation a condition of public funding for suicide prevention hotlines.

NAMI California recommends that a strong emphasis be also placed on 24/7 warm lines as important, less stigmatizing resources to have available for individuals before the situation they face becomes life threatening.

This Work Plan should make note of the network of hotlines already in use as part of the National Suicide Prevention Lifeline, operated by over 140 crisis centers nationwide and how to link with these, while expanding coverage for statewide use.

Note on Recommended Action SP 3.1 – Launch and sustain a suicide prevention education campaign with messages that have been tested to be effective for diverse communities and address warning signs, suicide risk, protective factors, and how to get help.
Appendix 7
California Mental Health Services Authority (CalMHSA)
Draft Implementation Work Plan Comments Verbatim

Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

Although SP 3.1 was not included in this Work Plan, it was recommended by 6 statewide organizations and 8 county organizations. SP 3.1 would appear to serve as the basis for the suicide prevention campaign mentioned in SP 3.2 and was intended to be linked with SP 3.2, but it appears that SP 3.2 was selected without the foundation of SP 3.1. Q: Will there be new materials created for the campaign referred to in SP 3.2 or is its primary purpose to serve a linking function between existing campaigns?

Pages 28-31

Recommended Action: SP 3.2 - Coordinate the suicide prevention education campaign with any existing social marketing campaign designed to eliminate stigma and discrimination toward individuals with mental illness and their families.

Will there be an attempt made to assess the effectiveness of existing campaigns? NAMI California recommends utilizing real life true stories and personal voices of consumers and CalMHSA family members with lived experience as an effective tool for sharing knowledge, while reducing stigma and making an impact on attitude change.

Stigma & Discrimination Reduction

pp. 45-60

Importance of Integrating Lived Experience

As expressed in our public comment of August 31, 2010, there is no substitute for lived experience when it comes to informing strategies that strive to reduce or eliminate the stigma and discrimination associated with serious mental health conditions. There is no greater spokesperson than a consumer or family member who is able to effectively share his or her story, or bring his perspective to the work they do and the life they live. This may take the form of presentations to a variety of community groups, or it may be expressed informally in the way one’s experience is expressed in his or her work and personal interactions inside or outside of the public mental health system. Individuals with lived experience across our state embody
people from all walks of life. They include people from across all cultural, age, and socioeconomic boundaries who compassionately advocate for peers and family members. They include well educated professionals who are currently delivering care and developing and administering policy, those who are earning undergraduate, masters, Ph.D., and medical degrees, all while keeping their own story or the story of a loved one at the heart of all they do. More support must be given to people who wish to be engaged in this capacity. This is what will transform how we as a society view mental illness and, ultimately, is what will transform the effectiveness of service delivery within our state, moving it closer to the recovery model envisioned by the Mental Health Services Act.

There are definite ways to translate the value of lived experience into all strategies outlined in the PEI Statewide Program for Stigma & Discrimination Reduction. NAMI California appreciates the inclusion in CalMHSA’s Work Plan of many strategies designed to achieve this goal. We are also pleased that CalMHSA has included the following, specific recommended actions as a result of the stakeholder process.

Pages 45-52

**Recommended Action SDR 1.3** – Create opportunities and forums for strengthening relationships and understanding between consumers, family members, and the larger community.

NAMI California notes that the language found in the deliverable associated with SDR 1.3 is vague enough to allow the possible misinterpretation that no specific action is required to support, implement and expand these forums: “Rely on mental health consumers and family members to raise awareness of the importance of mental health across the lifespan.” The words “rely on” do not specify whether the program will expand the efforts already being engaged in by consumers and family members. This direction should be clear as to what support will be given to consumers and family members to perform this function.

**Recommended Action SDR 1.5** – Recognize peer-run and peer-led programs as an important means for reducing stigma.
NAMI California notes that peer-run and peer led programs are essential to providing the first-person education and support needed to reduce self-stigmatization and encourage the realization of individual worth and wellness. The importance of being welcomed, supported, educated and mentored by those who have “been there” cannot be overemphasized in its impact on supporting recovery.

NAMI California emphasizes the need to include in addition to the current deliverables for this recommended action the opportunity for applicants to apply for direct support of peer and family run programs that provide education and support.

With regard to the deliverables directed toward “increased support for those closely involved with the lives of individuals facing mental health challenges” what you have outlined in the Work Plan appears limited and/or vague:

- Re “applying innovative information technologies that will allow parents and caregivers to obtain accurate information, guidance and referrals to seek needed services.” Increasing access to “innovative information technology” is important, but so is the actual “obtaining accurate information, guidance and referrals.” NAMI California requests that the emphasis first be placed on improving the information, guidance and referrals given before improving the technology.

- We agree that non-traditional community locations should be identified for the distribution of information. However, this deliverable should be expanded to ensure that funds are being secured to provide the actual resources for distribution, including resources to expand the languages in which these resources are offered.

- Finally, and most importantly, there is no deliverable outlined in this section that emphasizes the need for providing family member to family member education and support for those in need. How else to best address stigma than by building capacity for the mentoring being done by family members and peers who have gone through and are still going through similar struggles?
Appendix 7
California Mental Health Services Authority (CalMHSA)
Draft Implementation Work Plan Comments Verbatim

Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

Recommended Action SDR 2.3 – Ensure that mental health services are delivered in non-traditional, non-stigmatizing community and school sites.

NAMI California appreciates the inclusion of this recommended action after CalMHSA’s initial prioritization. This has widespread support from statewide community stakeholders.

Student Mental Health

pp. 61-71

NAMI California incorporates our previous written comments on Student Mental Health. In so doing, we preface this response with the overarching statement that not one of these individual strategies can operate successfully on its own. The basis for our input into each of these PEI Statewide Programs is the recognition that the theme of Stigma and Discrimination Reduction underlies the success of any and all related programs, including Suicide Prevention and Student CalMHSA November 6, 2010 Page 8

Mental Health. Moving forward, it will be important to acknowledge that all institutions and individuals bear remnants of societal stigma, and schools are no exception.

In responding to this Work Plan, NAMI California acknowledges the exceptional effort the California Community College Chancellor’s Office (CCCO) has put into their response to the Cal MHSA Work Plan. In recognition of the expertise of advocates working in mental health and education, we incorporate the recommendations of the CCCO and the California Department of Education herein. Additionally, in recognition of the expertise of lived experience and the experience of being a student and transition age youth in a university setting, NAMI California incorporates the following response of mental health advocate and California Mental Health Planning Council member, Marissa Lee, as follows: Suggested Change: “The program would fund training activities for students, faculty, staff or administrators to raise awareness of issues of mental health, wellness on college campuses, and an understanding of the legal disability rights of students with mental illness.” (Page 64)
In addition to incorporating the above recommendations, NAMI California emphasizes the need for all systems of education (both K-12 and Higher Education) to work together with consumers, family members, and students and teachers of all institutions to define together the programs that will work best for them. Without this widespread involvement in planning by these participants, efforts will not be as effective.

NAMI California echoes the concerns of mental health and education advocates who have consistently voiced that the Strategic Planning Process for Student Mental Health has not been as extensive as the other two PEI Statewide Programs. Therefore, an emphasis on continuing and strengthening planning to include the involvement of students, families, teachers and administration from all systems of education needs to play an important role in the implementation of all MHSA components.

We appreciate your thoughtful consideration of our comments.

Sincerely,

Kathleen Derby
MHSA Policy Coordinator
cc: Edward Walker, LCSW, Program Director, CalMHSA
Dorothy Hendrickson, President, Board of Directors, NAMI California

<table>
<thead>
<tr>
<th>Public Comment Date: 11/06/2010</th>
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<tbody>
<tr>
<td>Submitted by: California Department of Aging</td>
</tr>
<tr>
<td>Section Referenced: Pages 12, 13, 15, 16, 17, 18, 20, 21, 29, 30, 33, 34, 38, 40, 44, 49, 50, 51, A2.1, A2.2, A2.3, A2.4, A2.5, A2.6, and A2.9</td>
</tr>
</tbody>
</table>
November 6, 2010

California Mental Health Services Authority (CalMHSA)
Attention: Laura Li
George Hills Company, Inc.
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670-6394

Dear Ms. Li:

The California Department of Aging (CDA) is submitting comments on the draft California Mental Health Services Authority (CalMHSA) Statewide Prevention and Early Intervention (PEI) Implementation Work Plan dated October 7, 2010. Our comments are specific to suicide prevention and stigma/discrimination reduction.

Previously, CDA submitted its priority Recommended Actions with substantive comments to CalMHSA on August 31, 2010, and provided written comments on draft Statewide PEI Implementation Work Plans dated September 22, 2010, and September 27, 2010. Our comments on the current draft Work Plan are to ensure the following:

- A lifespan approach to the implementation of all “deliverables” identified in the Work Plan (e.g., deliverables must be inclusive of children/youth, transition age youth, adults, older adults);

- Implementation of culturally and linguistically competent strategies that will reach diverse populations across all age groups including diverse seniors;

- Inclusion of older adult service providers and programs when identifying gatekeepers, community/system partners and non-traditional settings to prevent suicide and reduce stigma and discrimination for older adults.
These expectations are consistent with two of the “Principles and Policy Directions” identified in the draft CalMHSA Implementation Work Plan (page 4):

- “All initiatives should have a life span appropriate focus for children, transition age youth, adults and older adults;” and
- “All initiatives should be culturally and linguistically competent, respectful and inclusive of California’s diverse population.”

CDA’s proposed revisions are included in Attachment 1 and reflect our desire for more specificity in the program descriptions and deliverables regarding these principles.

Also, CDA recommends including a “Glossary” for the Request for Proposal (RFP) to define key terms such as lifespan approach, cultural and linguistic competence, diverse populations, gatekeepers, system/community partners and others to ensure uniformity of interpretation. CDA would be happy to provide CalMHSA with information for a glossary specific to “aging service providers and programs.”

Please contact me if you have any questions. CDA will continue to be a collaborative partner with CalMHSA to ensure that older Californians benefit from the MHSA PEI Statewide Projects who are at-risk for suicide and/or experiencing “multiple stigmas living with mental health challenges who are also faced with discrimination based on their age, race, ethnicity, sex, sexual orientation, gender identity, physical disability or other societal biases.” (Stigma/Discrimination Reduction Recommended Action 1.6, page 48.)

Thank you.

Sincerely,

Lin Benjamin, MSW, MHA
Geriatric Mental Health Specialist
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

California Department of Aging  
(916) 928-7890; lbenjamin@aging.ca.gov  
cc: Lynn Daucher, Director, CDA  
Lora Connolly, Chief Deputy Director, CDA  
Edmond Long, Deputy Director, Long-Term Care and Aging Services Division, CDA

**Attachment 1 (CDA Proposed Revisions)**

**Attachment 1**

| California Department of Aging (CDA) Proposed Revisions to the CalMHSA Work Plan Dated October 7, 2010  
(Proposed Revisions on Deliverables Also Need to be Included in Revised Appendix 2) |

<table>
<thead>
<tr>
<th>Page Number</th>
<th>Location in Document</th>
<th>Proposed Language (Underlined)</th>
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</table>
| 12          | Outcomes, Suicide Prevention | • “Reduced Suicide Rates In California across the lifespan including diverse populations.”  
(Recommend establishing annual benchmark reduction percentages.)  
• “Increased Capacity and Improved Early Identification, Early Intervention Services and Activities for Consumers who are At-Risk for |
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Comment</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Suicidal Behaviors</td>
<td>across all age groups and diverse populations.</td>
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<tr>
<td>• “Improved Availability, Accessibility, and Quality of Services for those Historically Underserved Racial, Ethnic, and Cultural Groups across all ages with High Suicide Rates.</td>
<td></td>
</tr>
<tr>
<td>• “Reduced Disparities in the Availability, Accessibility, and Quality of Services for Historically Underserved Racial, Ethnic, and Cultural Groups across all ages.</td>
<td></td>
</tr>
<tr>
<td><strong>13</strong></td>
<td>Second Bullet from the Bottom “Work with data.”</td>
</tr>
<tr>
<td></td>
<td>“Intervention activities should target periods of time when surveillance data have indicated that suicide risk is high (e.g. onset of a mental illness particularly depression and after a hospital discharge). Recognition of early signs of mental health problems, particularly depression, is one of the most effective ways to prevent suicide.</td>
</tr>
<tr>
<td><strong>15 &amp; 16</strong></td>
<td>SP 1.12</td>
</tr>
<tr>
<td></td>
<td>SP 1.12 is missing on these pages</td>
</tr>
<tr>
<td><strong>16</strong></td>
<td>SP 1.3, 1.4 Second Paragraph</td>
</tr>
</tbody>
</table>
| | “A statewide network will be created that will educate gatekeepers for all age groups including diverse populations, provide technical assistance to
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Comment ID</th>
<th>Section(s)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>SP 1.3, 1.4</td>
<td>“Recognition of early signs of mental health problems, particularly depression, is one of the most effective ways to prevent suicide.”</td>
</tr>
<tr>
<td>18</td>
<td>SP 1.3, 1.4</td>
<td>“A statewide network will be created that will establish partnerships across systems and disciplines, educate gatekeepers and develop suicide prevention trainings specific to all age groups and diverse populations, and convene state and regional forums and symposiums on Suicide Prevention.”</td>
</tr>
<tr>
<td>18</td>
<td>SP 1.3, 1.4</td>
<td>“Suicide Prevention Workgroups will be established and convened to address population-specific roles across all age groups and diverse populations in preventing, assessing, and treating suicidal behavior, including the influence of culture. . . .”</td>
</tr>
<tr>
<td>20</td>
<td>SP 1.11, 1.13</td>
<td>“A key goal is to reduce disparities in the availability, accessibility, and quality of services for racial, ethnic,”</td>
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<tr>
<td>Program Description</td>
<td>First Paragraph</td>
<td>Deliverables</td>
</tr>
<tr>
<td>---------------------</td>
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<tr>
<td>and cultural groups that have been historically underserved <em>across all age groups</em>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 SP 1.11, 1.13 Program Deliverables</td>
<td>“Teach suicide risk and ‘recognize and intervene’ strategies and skills in a variety of personnel systems and community environments <em>such as health clinics (e.g., primary care and prenatal care), older adult service providers, mental health centers, emergency response systems, crisis centers, alcohol and drug programs, etc.</em>.”</td>
<td>(Inserted information from second paragraph on page 20 into deliverable)</td>
</tr>
<tr>
<td>20 &amp; 21 SP 1.11, 1.13 Program</td>
<td>“Indentify and implement innovative outreach and intervention strategies that specifically target historically underserved racial and ethnic groups and...”</td>
<td>(Include same information in Appendix 2, Page A2.2 for cross referencing)</td>
</tr>
<tr>
<td>Deliverables</td>
<td>other at-risk populations <em>across the lifespan.</em></td>
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<td>--------------</td>
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<tr>
<td>Bullet 3</td>
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</table>

<p>| 29 | SP 3.2, 3.3, 3.7 Program Description First Paragraph | “Once developed, electronic and print media messages will be disseminated to communities to educate and raise awareness about suicide risks and prevention, and mental health <em>across the lifespan including diverse populations.</em>” |
|     |                                               |                                               |
| 30 | SP 3.2, 3.2, 3.7 Program Deliverables Bullet 3 | “Disseminate electronic . . . educate and raise awareness about suicide risks and prevention, and mental health <em>across the lifespan including diverse populations.</em>” |
|     |                                               |                                               |
| 33 | SP 3.8, 3.9, 3.11 Program Description Fourth Paragraph | “Social support in a community of peers is especially important to vulnerable populations <em>across all age groups and diverse populations.</em>” |
| 34 | SP 3.8, 3.9, 3.11 Program Deliverables Bullet 1 | “Provide family, peer, and consumer education through evidence based population-specific gatekeeper training models that identify and implement population-specific strategies and promote...” Population-specific gatekeeper training and strategies should be inclusive of all populations according to age, race, ethnicity, culture, gender, sexual orientation. |
| 34 | SP 3.8, 3.9, 3.11 Program Deliverable Bullet 4 | “Conduct regional train-the-trainer gatekeeper training utilizing models that have been effective with specific populations across the lifespan including racially, ethnically and culturally diverse communities.” |
| 34 | SP 3.8, 3.9, 3.11 Program Deliverables Bullet 4 | “Incorporate and build capacity for peer support and peer operated services models for consumers of all ages and within diverse communities...” |</p>
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<tbody>
<tr>
<td>38</td>
<td>SP 2.1, 2.2, 2.5</td>
<td>“Convene expert workgroups and panels with participants who understand suicide prevention issues specific to populations by age, gender including sexual orientation, race, ethnicity and culture.”</td>
</tr>
<tr>
<td>39</td>
<td>SP 3.8, 3.9, 3.11</td>
<td>“Gatekeeper training targets a broad range of people in the community, for example: School health personnel, . . , senior center staff and other aging services providers.”</td>
</tr>
<tr>
<td>40</td>
<td>SP 3.8, 3.9, 3.11</td>
<td>“Identify and implement . . across the lifespan and within diverse populations.”</td>
</tr>
<tr>
<td>44</td>
<td>SP 4.2, 4.3, 4.5, 4.6</td>
<td>“Develop new evidence-based practices from”</td>
</tr>
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</table>
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Program Deliverables</th>
<th>Deliverables</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Bullet 1</td>
<td></td>
<td>community promising practices; ... for specific populations <em>across the lifespan and within diverse communities.</em></td>
</tr>
<tr>
<td>44</td>
<td>SP 4.2, 4.3, 4.5, 4.6 Program Deliverables Bullet 3</td>
<td>“Improve data collection, surveillance ... in diverse populations <em>across all age groups.</em>”</td>
</tr>
<tr>
<td>49</td>
<td>SDR 1.1, 1.3, 1.5, 1.6, 1.7 Program Description Bullet 2</td>
<td>“Develop messages and relevant materials for the public that explain mental health challenges and promote social inclusion <em>across the lifespan and within racially, ethnically and culturally diverse populations.</em>”</td>
</tr>
<tr>
<td>50</td>
<td>SDR 1.1, 1.3, 1.5,</td>
<td>“Develop local speaker bureaus, presentations, and forums that feature peers <em>from across the lifespan</em>”</td>
</tr>
</tbody>
</table>
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

| CDA Requests | SDR 1.1, 1.3, 1.5, 1.6, 1.7 | “Applicants will address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases, with efforts to:”

(Inserted language taken directly from SDR 1.6.) |
|---|---|---|
| 50 | SDR 1.1, 1.3, 1.5, 1.6, 1.7 | “Applicants will address increased support for those closely involved with the lives of individuals facing mental health challenges with efforts to:”

- “Apply innovative information technologies that will allow parents and caregivers to obtain accurate information, guidance, and referrals to seek needed services.” |

| 51 | SDR 1.1, 1.3, 1.5, 1.6, 1.7 | and diverse populations who are successfully dealing with…” |

<table>
<thead>
<tr>
<th>Program Description</th>
<th>1.6, 1.7</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bullet 3</td>
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</table>
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>Revision</th>
<th>Proposed Language (Underlined)</th>
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</thead>
<tbody>
<tr>
<td>• “Identify non-traditional community locations to distribute information on available mental health resources for populations across the lifespan and in underserved ethnic, racial and cultural populations.”</td>
<td></td>
</tr>
</tbody>
</table>

**CDA Proposed Revisions to Appendix 2 (dated November 12, 2010)**

The deliverables in the revised Appendix 2 are less specific than those described in the text of the Work Plan dated October 7, 2012. CDA recommends that the deliverable language in the main text of the Work Plan be considered the primary source of information for deliverables. Appendix 2 would provide a “snap shot.” Therefore, the descriptions of deliverables in the main text and Appendix 2 should be consistent for cross-referencing purposes.

<table>
<thead>
<tr>
<th>Page Number</th>
<th>Location in Document</th>
<th>Proposed Language (Underlined)</th>
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</thead>
</table>
| A2.1        | Priority 1           | “The purpose of the Statewide Suicide Prevention Network Program (SPNP) is to serve as the focal point for statewide suicide prevention activities, establish partnerships across systems and disciplines, convene population-specific working groups by age and diverse populations to promote suicide prevention programs that reduce or eliminate service gaps to at-risk populations across the
Appendix 7  
California Mental Health Services Authority (CalMHSA)  
Draft Implementation Work Plan Comments Verbatim

### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

<table>
<thead>
<tr>
<th>SP, Comment</th>
<th>Deliverables</th>
<th>Bullet Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>A2.1</td>
<td>SP 1.3</td>
<td>• “Engage a broad spectrum of partners including business community, multicultural and community-based organizations, community gatekeepers, etc. for all age groups and diverse populations.”</td>
</tr>
</tbody>
</table>
|             | Goals        | • “Improve early identification and early intervention for at-risk suicidal behaviors across the lifespan and within diverse populations.”  
|             | Bullet 2, 3  | • Increase referrals of individuals across all age groups and diverse populations with behaviors that indicate risk of suicide. |
| A2.2        | SP 1.4       | • Convene topic-specific workgroups for populations across the lifespan including diverse populations.  
|             | Bullet 1, 2  | • Identify gatekeeper models to provide education and training that have been effective with specific age groups and diverse populations. |
### Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

|   | SP 1.4 Goals  
|   | SP 1.12 Recommended Action SP  
|   |   |
|---|---|---|
| A2.2 | SP 1.4 Goals  
|   | Bullet 1  |
| A.2.3-2.5 CDA Requests  
| CalMHSA Response to Proposed Revisions  |
| SP 1.12 Recommended Action SP  
| Program Deliverables  
| Goals  |
|   | “Integrate suicide prevention programs into kindergarten through grade twelve (K-12) and higher education institutions, existing community-based services for older adults, employee assistance programs and the workplace and the criminal and juvenile justice systems.”  
|   |
|   | The Program Deliverables for Recommended Action 1.12 in the revised Appendix 2 do not include the following deliverable for older adults that was listed in the Program Deliverables on page 27:  
|   | “Increase the availability of community-based programs that target older adult mental health, and that complement outreach, engagement, and education opportunities that currently exist within the local community structure, and are services that older adults commonly use.”  
|   | CDA would like this older-adult specific deliverable to be inserted into the revised Appendix 2 on page A2.4 and also to remain in the main text of the Work Plan.
There also needs to be a corresponding **Goal** for the older adult deliverable in Appendix 2, page A2.4. For example:

- **Enhance the capacity of older adult service providers, programs and gatekeepers to identify the signs and symptoms of depression and suicide risk, and to provide appropriate suicide prevention interventions and referral services.**

<table>
<thead>
<tr>
<th>A.2.4 – A.2.5</th>
<th>SP 1.5, 1.6 Program Deliverables</th>
<th>Include as one of the Program Deliverables in Appendix 2 the following deliverable that was identified in the Program Deliverables of SP 1.5 &amp; 1.6 on page 23, Bullet #2:</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDA Requests</td>
<td></td>
<td>• “Hotlines should target specific populations such as youth, older adults ...”</td>
</tr>
<tr>
<td>CalMHSA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Response to this Proposed Revision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A2.6</td>
<td>SP 3.2 Program Deliverables Bullets 1, 2</td>
<td>• “Identify and implement population-specific strategies that promote suicide prevention across the lifespan and within diverse populations.”</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• “Develop and implement age-appropriate, multi-language education campaign targeting at risk”</td>
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<td>-----</td>
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<td>----------------------------------------------------------------</td>
</tr>
<tr>
<td>A2.9</td>
<td>SP 3.9 Program Deliverables Bullet 5</td>
<td>“Establish a partnership with aging services providers in California to develop a statewide training model that is available online for health and aging service providers.”</td>
</tr>
</tbody>
</table>

15. **Public Comment Date: 11/05/2010**

**Submitted by:** California Department of Education

**Section Referenced:** Pages 66, 67, 68, 69, and 70

November 5, 2010

To: CalMHSA

From: Monica Nepomuceno, Consultant, California Department of Education

916-323-2212 mnepomucneo@cde.ca.gov

Subject: Work Plan Comments

Page 66: The acronym SMHIP is not clear, if you are referring to the Student Mental Health Initiative, I believe the acronym is SMHI without the “P”.

Page 67: Request that the “Student Mental Health Policy Workgroup” include state level representatives who not only have
expertise in the financing of school mental health programs but to include representatives who have practical experience in the actual implementation of mental health programs for children and youth as well as experience in advocating for children and youth with mental health issues. In addition, this workgroup should serve as an advisory body that oversees the development and disbursement of grants through the SMHI.

The workgroup should not be restricted to identify only policy changes related to sustainable funding but should include policy related to overall school/student mental health.

Page 68: Does the title “The Regional K-12 Program” refer to the 11 superintendent regions? This title needs some clarification in the narrative.

The first paragraph refers to “mental health educational programs for students that include a focus on reduction, incorporate age-appropriate, etc.” It is unclear what is to be reduced, is it suicide, or the debilitating mental health incidents? Please clarify.

Page 68: Second paragraph: second sentence appears to be incomplete and unclear on what is meant by consideration. Will youth from these populations be considered for providing peer-to-peer support for those peers in need? (this is repeated on page 69 -7th point- in the same format).

Page 68: Third paragraph:
Should read “....the use of online tools.”

Page 69: There is no mention of applicants designing their programs to be racially, ethnically and culturally appropriate.

Page 69: Ninth point: Expand list of personnel to include frontline staff (i.e. secretaries, attendance clerks, cafeteria workers, yard duty) who often identify mental health needs in an unstructured setting. Many of these frontline staff are responsible for reprimanding, stigmatizing and lacking sensitivity to students with mental health needs. (Perhaps this should also be repeated
under point #3 Education and Training on page 70).

Page 70: Educate high school students on mental health beyond the minimal psychology course that may be taught in high school. Many current and former high school students have contacted the California Department of Education inquiring about the lack of mental health courses in California high schools. Students should be given information on recognizing mental health disorders, this may help some students self identify or assist in the identification of peers in need of mental health services.

Page 70: Include not only the development of relationships between school/district staff and county mental health departments but critically important is the maintenance and sustainability of these relationships.

16. **Public Comment Date: 11/06/2010**

**Submitted by: California Youth Empowerment Network (CAYEN)**

**Section Referenced: Appendix 2**

**CALIFORNIA YOUTH EMPOWERMENT NETWORK (CAYEN)**

Amber Burkan, Director - aburkan@mhac.org - 916.557.1167

The California Youth Empowerment Network (CAYEN) was formed to develop, improve, and strengthen the voice of Transition Age Youth (TAY) in local and state-level policy. We accomplish this through educating and working with TAY to obtain their direct participation and opinions regarding policies that impact their lives.

Below please find feedback from CAYEN, which incorporates direct recommendations given by TAY across the state. While CAYEN agrees with many of the priorities, principles, and outcomes presented, we want to ensure that all parts of the CalMHSA work plan are clearly targeted to address individuals across the lifespan, taking into account age specific design and age
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appropriate programming. While the work plan frequently draws attention to “racial, ethnic, and cultural groups” we would like it made clear that all programs, practices, and outcomes are designed in age appropriate and age specific ways. Our concern is that if language is not included to specifically address age diversity and age appropriateness, that this sentiment may not be translated into the creating of the outcomes and writing of the RFPs.

In addition to referencing racial, ethnic, and cultural groups, we urge you to specifically include language to address deliverables across the life span, and include age specific and appropriate programs.

We would like to draw your attention to the public comment from the California Mental Health Planning Councils Older Adult System of Care and Children, Youth, and TAY System of Care Committees.

CAYEN strongly recommends that you fully incorporate all age specific recommended language changes presented by these two groups.

All below references are for Appendix two, with CAYEN recommendations for language changes in bold.

Appendix 2:

Suicide Prevention

Priority 1: Creating a System of Suicide Prevention – Introduction

- In the introduction to this priority, we feel it is crucial that you change the language to read “reduce disparities in the availability, accessibility, and quality of services for historically underserved racial, ethnic, and cultural groups across the lifespan.” It is critical that you include “cultural groups” and not just address historically underserved racial and ethnic populations. By not including “cultural groups” it leaves room for plans to miss important populations such as the LGBT community which is a historically underserved and inappropriately served population as well. Many of the goals and
priorities in this section do address additional populations and it is important that is reflected in the priority description.

Recommended Action SP 1.3 (A2.1) -- Program Deliverables

- Suggested change: 5th point under program deliverables change to read: “Develop culturally and age specific suicide prevention trainings.”
  - Unless the trainings are both culturally and age appropriate they will not be effective.

Recommended Action SP 1.4 (A2.2) -- Program Deliverables

- TAY across the state felt very strongly that priority 3.10 be included in the work plan, which addressed the dissemination of, and education on, available resources. However, seeing as it was not included as a recommended action in the work plan, we urge you to add another program deliverable after “Identify develop, adapt and disseminate resources” which explicitly addresses the dissemination of information about how and where to access services and common roadblocks.

Recommended Action SP 1.13 (A2.3)

- Expand description, program deliverables, and goals to include the below words, so they each read “… underserved racial, ethnic, and cultural groups and other at-risk populations across the lifespan”

Recommended Action SP 1.12 (A2.3) – Program Deliverables

- Add a deliverable that reads “develop peer-to-peer services for suicide prevention on college campuses”
  - This is a technique that TAY felt was very helpful, and while we recognize it will also appear in the Student Mental Health section, in an effort to create programs that bridge between plans, we urge you to also include this
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

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**Recommended Action SP 3.9 (A2.9) – Program Deliverables**

- Change third point to read “Identify and implement population-specific strategies that promote suicide prevention across the lifespan”
  - “Population specific” may be interpreted as race, ethnicity, and cultural groups and it is important to ensure that age is also taken into account.

**Recommended Action SP 2.2 (A2.12) – Program Deliverables**

- Change first point to read “Assist professionals across systems and disciplines in their curriculum development efforts and ensure that curriculum addresses cultural and age specific needs.”

**Recommended Action SP 2.5 (A2.13) – Potential outcomes/indicators**

- Change first point to read: “Informed community and appropriate guidelines to support statewide training related to recognition of, **culturally competent and age** appropriate responses to individuals demonstrating suicide warning signs.”

**Recommended Action SP 4.3 (A2.13)**

- Change second paragraph to read “.... Use an inclusive process that considers cultural approaches, such as traditional healing practices, age specific interventions, and other measures that are relevant to target communities.”

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**Stigma and Discrimination Reduction**

**Recommended Action SDR 1.7 (A2.16) – Program Deliverables**

- Change third point to read “Develop electronic and print materials for the general **public that are culturally and age**
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<table>
<thead>
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<th><strong>appropriate</strong></th>
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<tr>
<td>o Creating age appropriate outreach materials was one of the key issues identified by TAY. When creating outreach materials for youth and young adults it must be specifically targeted and designed for their population.</td>
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<tr>
<td>• Change ninth point to read “Develop age appropriate electronic and print media to counter stigma and discrimination”</td>
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<tr>
<td>o Same rationale as above</td>
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**Recommended Action SDR 1.7 (A2.17) – Program Deliverables Peer-to-Peer Services**

| • Change the description to read: Programs that provide peer-run and peer-led programs are an important means for reducing stigma. **Program interventions will be age specific and culturally competent.** Program interventions may...” |

**Priority Two (A2.19) – Program Deliverables**

| • Change first point to read “Support ethnic diversity, cultural competency, and age appropriate training.” |
| • Change third point to read “Support training for mental health and system partner staff that serve populations across the lifespan, and underserved ethnic, racial, and cultural communities.” |

**Priority Four Recommended Action SDR 3.4 (A2.22)**

| • Change to read “Develop policies and mechanisms within the criminal and juvenile justice systems to....” |

**Priority Four Program Deliverables (A2.22)**

| • Change to read “Widely disseminate age appropriate user-friendly fact sheets with contact information for education...” |
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<th>and training purposes”</th>
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**Priority Four Goals (A2.22)**

- Change to “development of policies and mechanisms within the criminal and juvenile justice system to ...”

**Priority Four Potential Outcomes (A2.22)**

- Include **juvenile justice** in addition to “criminal justice” in all three potential outcomes

**Student Mental Health Initiative**

**Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention (A2.24)**

- Second paragraph, change to read “The UCSMHP will emphasize **age specific**, culturally relevant and appropriate approaches...”

- Add a deliverable regarding educating students on their rights to services, and addressing myths regarding loosing scholarships, confidentiality, parental rights, and being expelled.
  - Fear of perceived (and often incorrect) consequences to seeking mental health treatment often deters students from accessing services. Incorporated into peer-to-peer and educational trainings for students and faculty, must be a myth-busting curriculum around perceived and inaccurate barriers to students receiving services.

**Theme and Priority: Higher Education Training, Peer Support and Suicide Prevention**

**Goals: (A2.24)**

- Change to read “… the UCSMHP strategies aim to: Improve academic achievement, **increase student retention**, reduce
Appendix 7
California Mental Health Services Authority (CalMHSA)
Draft Implementation Work Plan Comments Verbatim

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discipline referrals...”

17. Public Comment Date: 11/06/2010
Submitted by: California Elder Mental Health and Aging Coalition
Section Referenced: Appendix 2

CEMHAC

California Elder Mental Health and Aging Coalition
November 6, 2010

Via email to laura.li@georgehills.com

CalMHSA
George Hills Company
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670-6394
Attn: Laura Li

From: California Elder Mental Health and Aging Coalition (CEMHAC) Subject: PEI Statewide Projects - Work Plan Comments

The California Elder Mental health and Aging Coalition appreciates the opportunity to provide input into the Statewide Prevention Early Intervention Implementation Plan. The mission of the California Elder Mental Health and Aging Coalition is to provide leadership, education, training and advocacy for the promotion and improvement of quality of life of older Californians.

California counties, representing individuals and families across the age span and ethnic, cultural and linguistic diverse
communities, have entrusted you with a big challenge, the implementation of the Statewide Prevention Early Intervention Projects. CEMHAC wishes the best as you rise to the challenge of delivering the Statewide Prevention and Early Intervention Program.

We appreciate your responsiveness and efforts to adequately represent the views and recommendations provided in this submission. Please find below and attached CEMHAC’s priorities and recommendation.

Older Adult Specific Recommendations

- To allocate 25% of the total Suicide Prevention and Early Intervention Project funding to address older adult unique needs.
- To identify, implement and evaluate Evidence–based and /or emerging Suicide and Stigma Reduction practices that effectively address needs of the diverse older adult communities of California, to include but not be limited to age, gender, region, cultural/linguistic needs, socio economic factors and level of literacy.
- To establish age specific outcomes for each of the projects. For older adults – the Suicide Prevention and Stigma and Discrimination Plans shall include:
  - Reducing isolation
  - Reducing incidence of depression
  - Increasing self-management / coping skills to manage chronic and terminal conditions
  - Increasing PCP, Aging Network professional and family caregiver education
  - Increasing family/caregiver support
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- Reducing stigma
- Reducing ageism
- Reducing disparities in healthcare.

Overall Plan

- To revise Plan to make it consistent across different sections/elements.
- To clearly state that the goal of this CalMHSA initiative is to deliver to California three developmentally appropriate, gender sensitive, ethnic and culturally/linguistic competent, as well responsive to the needs of rural communities, Statewide PEI Projects.
- To clearly define the role of California DMH in the statewide plan.
- To call out / name at front the key partners (Consumer, families, DMH PEI Suicide Prevention, Aging and Long Term Care, Public Health, Criminal Justice System, SAMHSA, etc.) to be involved in each of the projects.
- Add to the deliverable for all priorities, outcome tracking, monitoring, evaluating and reporting.
- In addition to budget allocated per project, to indicate the number of individuals to be served by each of the projects.

Please do not hesitate to contact us if you have any questions or concerns at email address vivina.criado@gmail.com or by telephone at 760-450-8609.

Sincerely,
Viviana Criado, MPA
Executive Director
California Elder Mental Health and Aging Coalition
2074 Ridgeline Ave
Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan

Vista, CA 92081

Enclosure: Appendix 2 : CalMHSA Initiatives with Program Deliverables, Goals, and Indicators/Outcomes – CEMHAC’s Recommendations as Track Changes.

18. Public Comment Date: 11/7/10

Submitted by: Delphine Brody, California Network of Mental Health Clients

Section Referenced:

November 7, 2010

California Mental Health Services Authority
Attention: Laura Li
George Hills Company
3043 Gold Canal Drive, Suite 200
Rancho Cordova, CA 95670-6394

Re: Comments on Proposed PEI Statewide Implementation Work Plan of October 7, 2010

Dear Ms. Li,

The California Network of Mental Health Clients is grateful for this opportunity to offer our comments on the California Mental Health Services Authority (CalMHSA) draft proposed PEI Statewide Implementation Work Plan of October 7, 2010.

For over 27 years, the California Network of Mental Health Clients has served as the statewide advocacy voice by and for mental
health clients/survivors, calling for policies that uphold our civil and human rights, dignity and social inclusion. In 2003-04, the Network conducted a client/survivor focus group study on stigma and discrimination in diverse settings throughout the Bay Area. Our findings are reported in “Normal People Don’t Want to Know Us: First-Hand Experiences and Perspectives on Stigma and Discrimination”.

Over the last three years, the Network has worked closely with other groups representing family members, underserved and unserved populations to advise the Mental Health Services Oversight and Accountability Commission (MHSOAC) and the State Department of Mental Health (DMH) in developing the California Strategic Plans on Suicide Prevention (June 2008) and Reducing Stigma and Discrimination (June 2009). We also commented on the Student Mental Health Initiative prior to its June 2007 approval by MHSOAC.

Today the Network represents over 1,900 Members with lived experience, many of whom are watching this process unfold with great anticipation. We view CalMHSA’s statewide implementation of these three PEI Statewide Projects as a momentous effort with the potential to positively impact the lives of clients/survivors in a historic way, and we ask that you give our comments careful consideration.

**Statewide Framework for Implementation**

On pages 4-6, the draft Work Plan lists “pertinent MHSOAC PEI Principles and Policy Directions” for statewide implementation. Notably absent from the list is the Commission’s first PEI Principle, “Continuous Stakeholder Involvement – Statewide projects require stakeholder involvement in a planning process whether they are locally, regionally or state administered; encourage

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This Principle, adopted by the Commission last September following a great deal of discussion and consensus-building within the MHSOAC Services Committee – whose members include community stakeholders as well as Commissioners and staff of government agencies – is incorporated in the MHSOAC Guidelines for PEI Statewide Programs as Requirement D, and it should be included prominently in this section of CalMHSA’s Work Plan.

Furthermore, CalMHSA should take more steps to incorporate this Principle into everyday practice. When Network Members and other local stakeholders learn about CalMHSA and its planning process, many are interested in getting involved or speaking at CalMHSA meetings, but many barriers continue to stand in their way. Below are a few ways to remove these barriers and improve CalMHSA’s efforts to involve stakeholders:

- Revise the structure of policy-setting committees such as the Implementation Ad Hoc Committee to include clients, family members and representatives of multicultural communities, as MHSOAC committees and most local MHSA committees do.

- Engage local stakeholder communities throughout CalMHSA’s process. As it stands, only about eight stakeholders attend CalMHSA Board meetings because the local stakeholder communities have not yet been engaged. The eight of us who regularly attend are staff of statewide membership organizations and state agencies, and we all find it extremely difficult to keep up with CalMHSA’s rapidly paced process in order to weigh in on plans, draft policies or other action items.

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- CalMHSA Member Counties should offer full travel reimbursement for clients, family members and unserved community members to attend and participate in the monthly Board meetings and on committees.

- Make the process more accessible, with centrally located meeting venues, larger meeting rooms, two-way call-in participation at each meeting, threshold language and ASL interpreting, more time allotted for public comment, public comment summaries included in meeting minutes, and a welcoming environment with peers on-hand to explain public comment rules and mentor newcomers on how to participate most effectively.

The Commission has adopted each of these policies, and along with funding for client and family representation, stakeholder outreach and engagement, these practices have greatly increased stakeholder participation there. The MHSOAC Principles indicate that CalMHSA is expected to conduct its meetings in as inclusive a manner. We strongly encourage the JPA to adopt these policies themselves.

Another MHSOAC PEI Statewide Principle that appears missing on pages 4-6 of the draft Work Plan is that of “Preserving State-wideness”, also reflected in the Guidelines (Requirement C). Although the Work Plan states “…Activities have statewide impact”, this Principle is minimally stated and should be expanded upon to better reflect Requirement C. Please note that the Guidelines do not mention a “regional effort” in the context used in the draft Work Plan, page 4, bullet point 2, as an allowable category of program that can be provided as part of a JPA Statewide Program implementation. This reference to a “regional effort” should either be rephrased as a replicable program of a multi-county collaborative, eligible for funding only for counties that opt out of a JPA program within this work plan, or omitted altogether.

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4 Ibid., pages 4-5.
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Section A. CalMHSA Strategic Plan on Suicide Prevention (SP)

For the purpose of these comments, we will be referring to both the draft Work Plan of October 7th (pages 11-44) and the more detailed draft Appendix 2 (pages A2.1-A2.15).

Priority One: Create a System of Suicide Prevention

Thank you for including Recommended Actions SP 1.3 (Develop a network of statewide public and private organizations to develop and implement strategies to prevent suicide), SP 1.12 (integrate SP programs into K-12 and higher ed, existing community-based services for older adults, employee assistance programs and the workplace, and the criminal and juvenile justice systems) and SP 1.13 (Develop and promote programs that appropriately reduce or eliminate service gaps for historically underserved racial and ethnic groups and other at-risk populations) in the introductory program description of CalMHSA’s Priority One, the Suicide Prevention Network Program (SPNP) on page 11 of the draft Work Plan.

The Network recommends that these be prioritized together with Action SP 1.8 (In each county, appoint a liaison to the State Office of Suicide Prevention [OSP], and build upon an existing body or convene a new SP advisory council to collectively address local SP issues, with membership including mental health clients, survivors of suicide attempts and family members, tribal representatives and Area Agencies on Aging, among others), Action SP 1.9 (to develop with a diverse representative group of stakeholders a local suicide prevention action plan whose purpose would include providing technical assistance to peer support programs), and Action SP 1.10 (Enhance links between systems and programs to better address gaps in services and identify resources to support local solutions). If implemented together, the SPNP will help reduce disparities impacting unserved and at-risk groups through local stakeholder involvement, integration, peer support, and enhanced links.

To the list of SPNP deliverables listed in Appendix 2 for Action SP 1.3 (page A2.1), we would like to see client, family, youth and peer support advocacy groups added to the broad spectrum of partners to be engaged. We especially appreciate the inclusion of development of culturally specific suicide prevention trainings and convening state and regional forums and symposiums on
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SP, and we hope that clients, TAYs, older adults, family members and underserved community members will be called upon as subject matter experts and presenters. For Action SP 1.12 (pages A2.3-A2.4), we would like to see each deliverable developed in consultation with mental health clients and survivors of suicide attempts from each specific population to be served.

Also, please note that although Action SP 1.12 is listed there as a component of the SPNP, and again in the Program Budget Projections on page 14 and in the Program Budget Detail for SP Priority One on pages 25-27, this Action does not appear in the breakdown of Actions for SP Priority One on Work Plan pages 15-16.

Priority Two: Develop and Coordinate a Statewide Social Marketing SP Campaign Program

The Network greatly appreciates CalMHSA’s inclusion of Action SP 3.11 (Incorporate and build capacity for peer support and peer-operated services models such as peer warm lines and peer-run crisis respite centers as a part of SP and follow-up services), along with Action SP 3.2 (Coordinate the SP campaign with an existing social marketing campaign to eliminate stigma and discrimination), in its Social Marketing SP Campaign Program (introduced on pages 11 and 12 of the Work Plan).

Peer support, peer-run service models and culturally traditional healing modalities often play a key role in suicide prevention for people who avoid mental health clinics and institutions, as well as for many who use them in conjunction with clinical services. Such programs are high on the list of programs that clients prefer. Client-operated programs such as peer-run crisis respite and warm lines have begun to proliferate around the country; increasingly, they are considered a necessary part of any community mental health continuum of care. Although proven highly effective, these programs have long been very under-funded as well as under-researched. Therefore we wish to first prioritize Action 3.11, and feel this action would be most effective in combination with Actions SP 1.9 (see above) and SP Action 4.3 (Identify or develop methodologies to promote the evaluation of promising community models to build their evidence base using an inclusive process that considers cultural approaches such as traditional healing practices and measures that are relevant to target communities). This combined approach will allow capacity building for peer support, provide peer programs with technical assistance, and develop ways to strengthen the evidence base for peer-
run programs and culturally traditional healing modalities.

Stigma and discrimination also factor prominently in clients' lives, contributing to the risk of suicide and suicide attempts as well as creating barriers to suicide prevention. With this in mind, we also support implementing Action SP 3.2 together with Action SP 3.6 (Build grassroots outreach and engagement efforts to coordinate with and tailor the statewide SP education campaign and activities to best meet community needs) and SP 2.1 (Convene expert workgroups to recommend, develop, disseminate, broadly promote and evaluate SP service and training guidelines and model curricula for targeted service providers that include direction to address stigma and discrimination-related barriers to suicide prevention across service sectors, in corrections and in schools).

In combination, these three Recommended Actions can most effectively coordinate public awareness campaigns with campaigns for equal rights, dignity and social inclusion, tailored to best meet the needs of diverse local communities, including unserved and underserved cultural populations at higher risk for suicide.

For Social Marketing SP Campaign Program Action 3.2 (Appendix 2, pages A2.6-A2.7), we would like to see each deliverable developed in consultation with mental health clients and survivors of suicide attempts from each specific population to be targeted with educational campaigns. For Action SP 3.11 deliverable 2 on page A2.10, rather than prepare another one-size-fits-all “how to” manual, we should follow the Zen Buddhist concept of Beginner’s Mind and allow local clients to decide how outreach and peer support should be done in their communities, as the late former community college professor, mental health client/survivor advocate and Network Cultural Competence Project Coordinator Maria Maceira-Lessley modeled in an innovative peer training on peer support and advocacy that she called “What Do You Want?” Beginner’s Mind is a humble approach that seeks clarity and understanding through the open mind of a novice, with an emphasis on keeping the mind open, taking the time to listen carefully and learn from many different perspectives, and avoiding making presumptions. With this approach, Maria held a series of meetings and focus groups with Latino/a clients in Madera and San Benito Counties, greatly expanding the breadth and depth of the Network's inclusion of unserved and underserved people and issues in rural areas. Maria chronicled the slow, intensive process of outreach and engagement, building trust slowly over a series of meetings and
conversations, planning community events together and allowing each community to develop focus group questions in their own way. Her informative accounts of this process, focus group findings and recommendations can be found in the Network’s 2007 Cultural Competency Project Report.\(^5\)

**Priority Three: Educate Communities to Take Action to Prevent Suicide**

The Network strongly supports CalMHSA’s prioritization ofRecommended Action SP 2.1 (see above) as part of its Development of Program Curriculum, along with **Actions SP 2.2** (Expand opportunities for SP training for selected occupations and facilities through long-term approaches, such as embedding suicide prevention training in existing licensing, credentialing, and graduate programs) and **SP 2.5** (Increase the priority of SP training through outreach and by disseminating, tailoring, and enhancing state training guidelines as necessary to meet local needs) on page 12 of the draft Work Plan.

For the latter two Actions, we recommend developing training curricula and guidelines in consultation with mental health clients and survivors of suicide attempts, including those from at-risk and underserved communities, and again utilizing the Beginner’s Mind approach to allow people with lived experience in targeted communities to develop the outreach venues and strategies themselves.

**Priority Four: Improve Suicide Prevention Program Effectiveness and System Accountability**

We are happy to see incorporated in this proposed program **Recommended Action SP 4.3** (see above), along with Actions SP 4.5 and SP 4.6 (Work Plan page 12). We are delighted to see that both Actions SP 4.3 and SP 4.6 include using **community-based participatory research methods** to develop methodologies to evaluate SP interventions on the state and local levels. **Clients/survivors should be consulted** in the development of these methodologies in addition to **unserved and underserved**

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cultural groups. Including these Actions in a statewide evaluation RFP with expectations of data collection for each program, as proposed in the Work Plan, is an excellent first step to the building the means to conduct the extensive data gathering required by the Guidelines.

Section B. CalMHSA Strategic Plan on Stigma and Discrimination Reduction

Priority One: Create a Supportive Environment

The Network is very pleased to see included in this program (introduced in the Work Plan on page 45) Recommended Actions SDR 1.1 (Create widespread understanding and recognition within the public and across all systems that people at different points in their lives experience different degrees of mental health from wellness to crisis, and persons living with mental health challenges have resilience and the capacity for recovery), SDR 1.3 (create opportunities and forums for strengthening relationships and understanding between clients, family members and the larger community), SDR 1.5 (recognize peer-run and peer-led programs as an important means for reducing stigma), SDR 1.6 (Address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases), and SDR 1.7 (Provide increased support for those closely involved with the lives of individuals facing mental health challenges).

Social devaluation and exclusion by society as a whole is our second highest priority. Widespread prejudice and discrimination interfere with recovery, including clients’ ability to access services, housing, employment and relationships, and SDR Actions 1.1, 1.3, 1.6 and 1.7 should help make a dent in this enormous yet seldom acknowledged societal problem.

Also, although the MHSA calls on mental health systems to promote the growth of consumer-operated services as a way to promote recovery and to create client jobs that fit clients’ needs, there has been much foot-dragging and backsliding in this area. Remedying this dire situation is also very high on our Members’ priority list. Many self-help programs have received insufficient levels of MHSA funding to make up for major cuts in their funding from Realignment and other public funding streams, forcing some self-help centers to close permanently, and we are hopeful that SDR 1.5 will be a strong first step towards
turning this troubling state of affairs into a triumph.

Discrimination by mental health service providers, law enforcement and the courts against clients of color, including disparities in access to mental health services, over-medication, disproportionate use of force, hospitalization, arrest and incarceration, is of great concern to our Membership. We recommend adoption of Core Principle 1 to implement culturally and linguistically competent strategies and programs that reduce disparities and reflect the values and beliefs of diverse populations along with Action 1.6 to address the multiple stigmas of persons living with mental health challenges who are also faced with discrimination based on their race, ethnicity, age, sex, sexual orientation, gender identity, physical disability, or other societal biases.

Priority Two: Promote Awareness, Accountability, and Changes in Values, Practices, Policies, and Procedures Across and Within Systems and Organizations

It is truly refreshing to see Actions SDR 2.1 (Initiate systematic reviews to identify and address stigmatizing and discriminatory language, behaviors, practices, and policies) – especially in local mental health systems, medical and education systems – and SDR 2.6 (Educate employers on the importance of mental health wellness for all employees), – especially to educate employers on their responsibilities to create work environments free of stigma and discrimination – as well as SDR 2.9 and SDR 2.10.

Our Members have repeatedly identified prejudicial attitudes and systemic abuse among mental health service providers as the number one priority area in which stigma and discrimination must be recognized and eliminated. Central to this problem is the widespread promotion among mental health service providers of the “medical model” conception of mental illness as a biological brain disease, including psychodiagnostic labeling and objectification, denial of clients’ civil and human rights, promotion of dependency on service providers, propagation of unproven and harmful medical model messages about clients, and the philosophical opposition and programmatic undermining of wellness/recovery. With this in mind, we wholeheartedly support SDR 2.1, but strongly recommend that it be implemented in combination with the following Recommended Actions with attention to the above concerns and with client/survivor advocacy organization representatives in leadership roles:
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<th><strong>Public Comment Submissions to October 7, 2010 CalMHSA Draft Implementation Work Plan</strong></th>
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<tr>
<td>• <strong>SDR 1.4</strong>, step 3, encourage mental health providers to assess their procedures to identify and eliminate any contributory actions to client self-stigma;</td>
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<tr>
<td>• <strong>SDR 1.8</strong> to reduce the effects of stigma in assessment, diagnosis, treatment planning and interventions (especially next steps 1 and 5);</td>
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<tr>
<td>• <strong>SDR 2.5</strong> to promote clients’ dignity and safety by utilizing informed consent as a means to ensure voluntary choice and eliminating the use of force and forced mental health treatment compliance (especially through step 3, developing and disseminating information on de-escalation approaches and techniques such as peer involvement for emergency room personnel, law enforcement, homeless shelter staff, and mental health providers, and step 4, providing increased support, education, training, and guidance to in-patient care staff to eliminate the use of seclusion and physical or pharmaceutical restraint);</td>
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<td>• <strong>SDR 3.1</strong> to increase awareness and understanding of existing laws and regulations that protect clients against discrimination (especially step 1 to develop and widely disseminate user-friendly fact sheets with contact information for education and training purposes on applicable state and federal laws for mental health systems);</td>
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<tr>
<td>• <strong>SDR 3.2</strong> to promote compliance with and enforcement of current antidiscrimination laws (especially step 6 to create and disseminate anti-stigma education materials for treatment teams and discharge planning staff at mental health facilities and staff at public guardians’ offices); and</td>
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| • **SDR 3.3** to work to enhance and/or amend current laws to further protect clients from discrimination (with regard to mental health laws, and including clients/survivor advocacy group representatives on the statewide committee along with legal experts and diverse community members that would evaluate existing laws for any embedded discriminatory
members are also concerned with counties’ inaction to create new full- or part-time client-designated positions with benefits, while those jobs that are being offered are temporary, low-paying part-time contractor positions without benefits, which deny a living wage while disrupting clients’ continued eligibility to receive disability benefits. Mental health jobs for clients have not increased noticeably at the management level; the pay is generally not comparable to that of clinicians. We are hopeful that SDR 2.6 will help to remedy this situation, but we recommend that SDR 2.7 also be implemented to expand opportunities for employment, professional development, upward mobility, retention, and success of mental health clients in public, nonprofit, and private sector workplaces by enforcing current laws and challenging hiring biases.

Internalized stigma is another major concern for our Members. When a person internalizes the prejudicial views of those around him or her, it can block any positive thoughts towards recovery. Internalized stigma also creates divisions between clients, such as when those whose career or opinions closely align with the mental health establishment reject and distance themselves from other clients who espouse values such as spiritual communities, self-help and client culture. To address this concern we recommend prioritizing Action 1.4, to reduce self-stigma.

Finally, prejudice and abuse by family members has contributed significantly to the adversity that clients face. In promoting clients’ reconciliation with their families and family members’ inclusion in adult clients' mental health decision-making without exception, the mental health system fails to recognize that for some clients, familial abuse has caused major psychological trauma, and this trauma has led to mental health problems. To address this concern, we recommend Action 1.3, step 1, specifically to utilize established community networks to sponsor dialogues among consumers, family members, and the larger public about the relationship between familial abuse, trauma and mental health issues.

For feedback on the other proposed SDR programs and deliverables and Section C, Student Mental Health Initiative, we will send CalMHSA an addendum to these comments as soon as possible.
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Please note also the following typographical and factual errors:


- Factual: Page 2, paragraph 5, sentence 2: “… and to respect the values of the California Mental Health Services Act.” [should read: … and to respect the values embodied in the General Standards set forth in the California Code of Regulations, Title 9, Division 1, Chapter 14 for the Mental Health Services Act.] Also, the MHSA General Standards listed in sentence 3 should be re-numbered and re-phrased as follows: (1) Community Collaboration; (2) Cultural Competence; (3) Client Driven mental health system for individuals of any age who are receiving or have received mental health services; (4) Family Driven mental health system for families of children and youth diagnosed with serious emotional disturbance; (5) Wellness, Recovery, and Resilience Focused; and (6) Integrated Service Experiences for clients and their families.

Thank you for taking the time to read our recommendations for implementation of these three historic and critical PEI Statewide Projects. Please feel free to contact us at 1-800-626-7447, ext. 19 or write to delphinebrody [at] californiACLients.org if you have any questions.

Sincerely,

Delphine Brody, MHSA & Public Policy Director
California Network of Mental Health Clients
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| Cc: | John Chaquica, CPA, MBA, ARM, Executive Director, CalMHSA  
|    | Edward Walker, LCSW, Program Director, CalMHSA  
|    | Sharon Kuehn, Executive Director, California Network of Mental Health Clien |
As background to discussions within the Implementation Work Plan are the following documents, which can be accessed on the CalMHSA Website homepage (www.calmhsa.org):

DMH Contract with CalMHSA
MHSOAC Guidelines
Strategic Plans
CalMHSA Procurement Policy (*to be posted upon CalMHSA Board of Directors approval*)